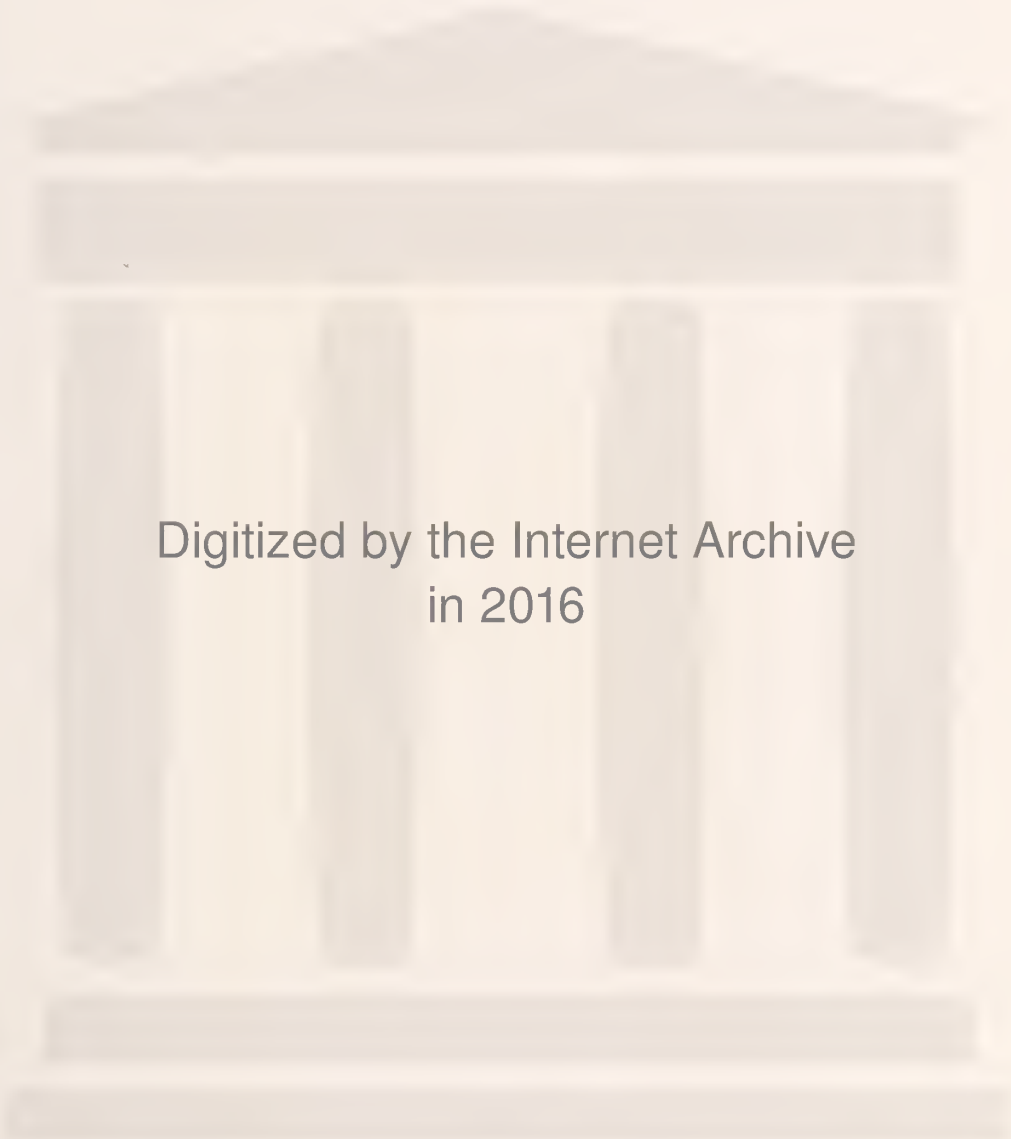
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the JOURNAL
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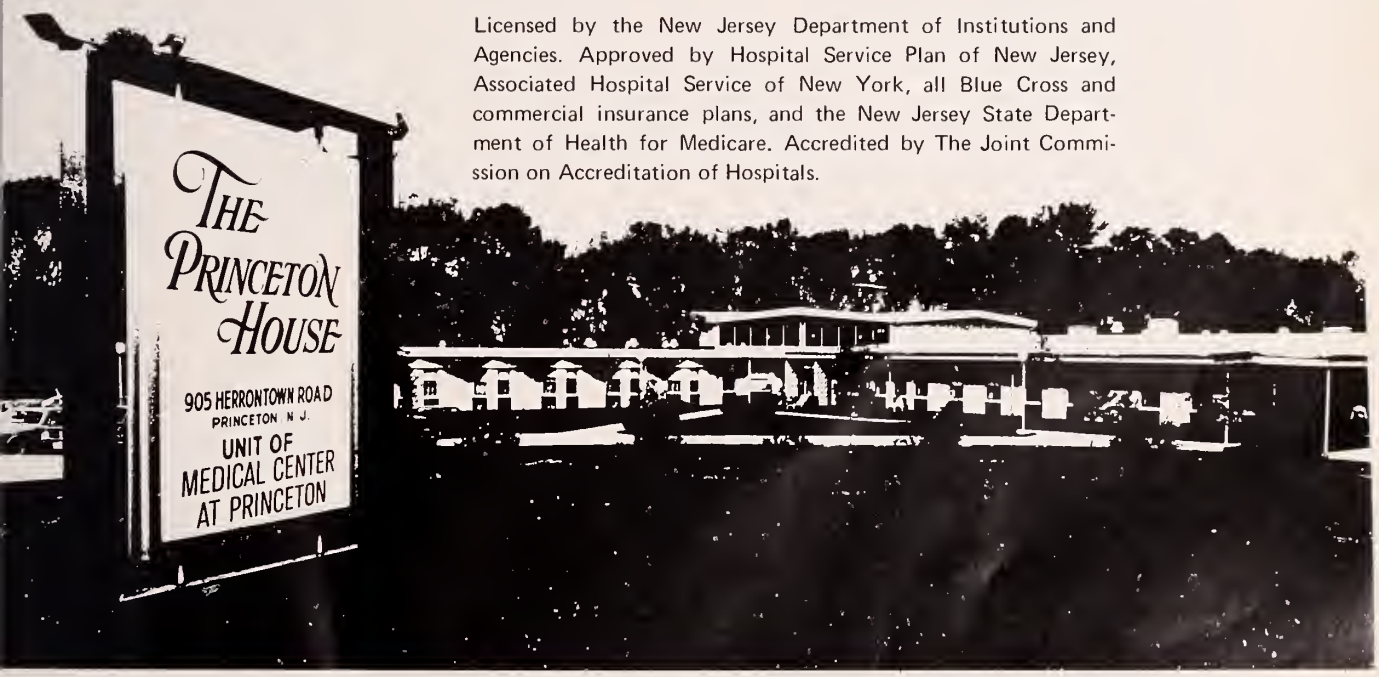
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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effect. Employ usual precautions in patients who are severely depressed, or with

Sleep for 7 to 8 hours without need to repeat dosage during the night

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on, lethargy, disorientation and
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r overdosage, have been reported.

Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

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Opinion & Dialogue

"Prescription drugs – who should determine the maker?"

Dispenser of Medicine

Clifton J. Latiolais
President
American Pharmaceutical Association



Maker of Medicine

C. Joseph Stetler
President
Pharmaceutical Manufacturers Association



"Too many doctors are indiffe ent to the economic consequences their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by form AMA Chief Executive F. J. L. Blasingame, M.D.

Doctor, are you indifferent...?

In discussing an anticipated in crease in Blue Shield rates, Dr. Blas ingame's newsletter had this to say:

"In general, it can be said, MD have given the impression they are not particularly concerned with the increase in cost of health care to the patients...

"True, an MD's training is primarily scientific, but in the real wor of practice, all of his scientific decisions have a price tag, or an econom impact. The economics of health ca beckon the practitioner's attention. Concern for economics of medicine

When the pharmacist recommends that a drug product other tha the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is nece sary for the prescriber to know that the change is being contemplated, and to be in a position to consent or demur. Without that opportunity, th unilateral decision of the pharmacis made in the absence of clinical kno edge of the patient, could expose hi to needless risks, and in addition, jeopardize the relationship between the professions of Pharmacy and Medicine. In my view, there is nothi in the pro-substitution argument tha offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowled about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degre puts him at a disadvantage. Most often, a practicing physician will ne expert knowledge of no more than 2

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uld be an obligation of medical ctice...

"Medical societies ought to con- t continuing campaigns to point the substantial savings that could ealized thru deductible insurance protection for catastrophic ill- s. At the very least, they should, in patients' interest, question the ics of any insurance organization raises health care costs by forc- policyholders to buy insurance may not need or want and prob- won't ever use.

"Too many doctors are indiffer- to the economic consequences of r decisions. Too many, for ex- ple, habitually hospitalize patients the convenience of the MD. It's sense to deny such habits exist...

"Doctors, thru their medical so- ies, have unhesitatingly appealed heir patients for support in the t against government interference the private practice of medicine. the public in the past has re- nded. It's time the American Med- Association and state and local dical societies paid off the debt by isive action to hold down the cost nedical care."

t of Drugs

Insurance rates and hospital rges are only two factors in health care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

---

30 drugs that he selects to treat the jority of conditions encountered in practice. Moreover, the physi- n's choice of a specific brand is sed on his knowledge of the pa- nt's medical history and current ndition, and his experiences with particular manufacturer's oduct.

Some substitution proponents ve argued that the dispensing of a escription is a simple two-party nsaction between the pharmacist d the patient, and that a substitut- g pharmacist may avoid even a chnical breach of contract by simply tifying the patient that he is making substitution. I would judge that v courts would be sympathetic vard a pharmacist who substituted thout physician approval and who dertook a legal defense that seeks make the patient responsible for e pharmacist's actions.

duced Prescription Prices?

Substitution advocates are ggesting to the consumer, and par- ularly the consumer activist, that duced prescription prices could llow legalization of substitution. e have seen absolutely no evidence justify this claim. To the contrary, perience in Alberta, Canada, where bstitution is authorized, suggests the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advocates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

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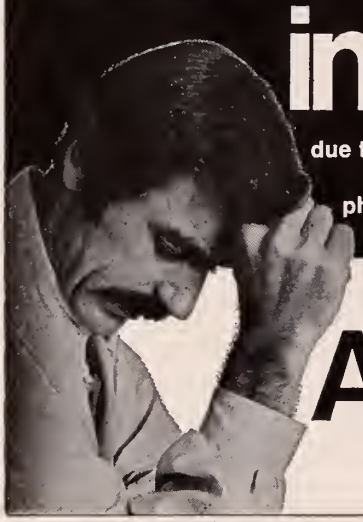
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References: 1. Montezano, P., and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Tiefl, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Heilman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. Farris, E. J., and Colton, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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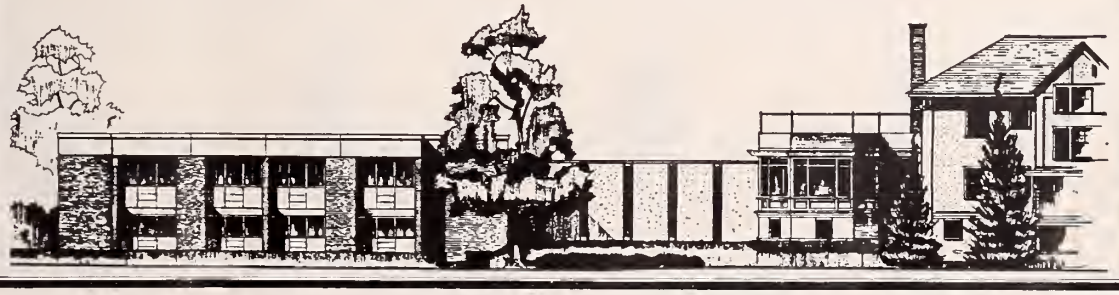
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

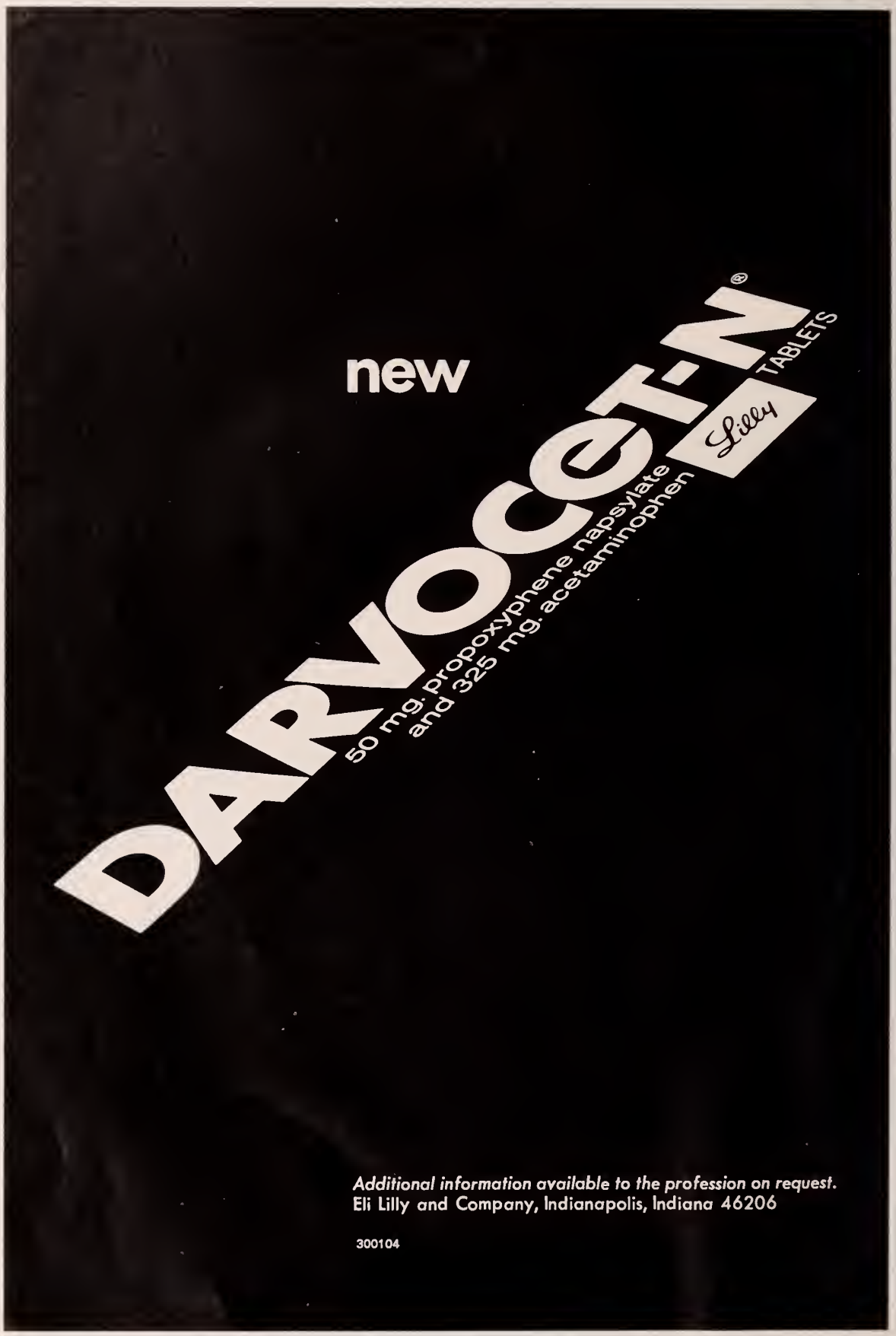
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EDITORIALS

The New Executive Director Vincent A. Maressa, B.A., J.D.

On June 1, 1973, Vincent Maressa became Executive Director of The Medical Society of New Jersey, succeeding Mr. Nevin. He had been our Executive Assistant since 1967 and was designated Assistant Executive officer in June 1972. Mr. Maressa, a native Trentonian, is an alumnus of the Temple University School of Law. He was a history major at St. Francis College in Loretto, Pennsylvania, and was active there in athletic and fraternal affairs. He has been admitted to practice before the State and Federal Courts, is a member of the State and American Bar Association, and the American Historical Society.

In his nearly six years of duty with The Medical Society of New Jersey, he has familiarized himself with every aspect of the Society's operation. He brings to his new office youthful zeal and vigor, experience in establishing and maintaining friendly and effective relationships with the officers and members, a well-rounded knowledge of the practical problems the Society faces, and time-tested administrative skills.

His staff will include two executive assistants, Mr. Joseph Lucci who will be assistant for medical and insurance affairs and Mr. Martin Johnson whose area of jurisdiction will include legislation and public relations. Mr. Lucci matriculated to Manhattan College in New York and Rider College in Trenton. Much of his employment has been in the insurance field and he is a member of the National Association of Life Underwriters. Mr. Johnson has been a clinical supervisor with the narcotic abuse division of the State Department of Health. He has done managerial and professional work for Warner-Chilcott, and, before that, for Smith, Kline and French. His bachelor's degree is from St. Joseph's College in Philadelphia; he also attended the University of Pennsylvania.

Public Hospitals and the Teaching of Medical Students

Nearly every large urban area (Newark, for instance) has a public hospital, frequently city-operated, to which indigent citizens must turn for hospital care. These are usually large institutions and if one thinks of patients as "teaching material" the hospitals provide a good source of such material. Speaking on this topic last summer (in a talk to the American Health Congress meeting in Chicago), Stanley S. Bergen, Jr., President of the College of Medicine and Dentistry of New Jersey, addressed himself to the dilemma that often develops between service needs and teaching needs, between the importance of respecting the dignity and privacy of the patient and making the patient available for examination by medical students. Here in the USA we have often considered individual choice of physician to be one of the glories of American practice, but such free choice is often not available in large municipal hospitals. Then, too, some medical decisions are made by interns, some by residents, and some by "attending physicians," at various levels, so sometimes the patient and family wonder "who's in charge here?"

Impairment of privacy is a problem in all kinds of public institutions and agencies from health insurance policies to income tax returns. If medical students need to get the "feel" of a rectal tumor, there may have to be a line-up of finger-gloved students taking turns in palpating the mass. Dr. Bergen has highlighted the emotional conflict: teaching and learning on one hand, versus direct patient service on the other. Some distress is produced by the necessary rotation of house staff among various services with an inevitable break in the continuity of patient care. The burgeoning of family-oriented comprehensive

care programs produces an added dimension to the problems in the pedagogic use of public hospitals. However, the system has some assets. Consultation is frequent and ungrudging. Highly specialized experts are available. The patient, indeed, has an elite team of medical care-takers. Few private patients could buy the manifold talents tapped by the patients in the university-affiliated public hospitals.

Dr. Bergen points out that to realize all the benefits, some rethinking is needed. The specific mission (service and teaching) must be clarified. The medical needs outside the local community must be considered. Adequate funding must be provided in spite of the tendency of many governments to buy for quantity rather than quality. Responsibilities to the entire medical community must be met. In general, the public hospital offers a rich and unique training resource for medical schools, and our profession must develop a blueprint for the better use of this facility.

Pediatricians and the New Jersey Diabetes Association

The goals of the New Jersey Diabetes Association are to promote better care of diabetics (both children and adult), to help the prevention of diabetes in the future through proper studies and research where possible, and to study and prevent the collateral vascular and other degenerative changes incident to the disease complex.

As an important phase of these objectives, special attention is needed to the problems of juvenile and adolescent diabetics. The differences between juvenile type onset and adult onset diabetes have been recognized for at least forty years and their characteristics are even now being further delineated. Every pediatrician should be vitally interested in any activity which would help to clarify this phase of the diabetic syndrome.

The New Jersey Diabetes Association has been running a camp for diabetic children for fifteen years and it is one of over forty others in this country alone. The essential features of all these camps are to supply a form of group security therapy for the diabetic children who fancy themselves separated from other people by their disease. The methods of accomplishing this objective vary from camp to camp, but have the common feature of giving the children an education in diabetes, to help themselves in conjunction with others, in the course of normal, full activities. Not all diabetic children must go to these camps, but there is a definite need for this facility for some of the children. In this phase of the over-all program the pediatrician would seem to have a special place.

The pediatrician and the internist must have an integrated approach to the syndrome of diabetes mellitus not for the sake of showing differences in phases of the disease, but to compliment each other's efforts for the common goal. With the increased numbers of children diabetics, it is high time that the community of pediatricians show a more lively interest in the subject. Those methods which are meant more for the young diabetic need the pediatrician's knowledge to get the whole picture of caring for all diabetics.

The Relativity of Our Terms

When you come to think of it, most of our adjectives are relative. How anemic must one be to warrant the word "anemic?" How sterile is sterility, both in the sense of being unable to reproduce and being (relatively) free from bacteria? So with such adjectives as malnourished, overweight, serologically positive, and the like. As a matter of fact, almost all subjects (again speaking relatively) are placed along a spectrum with little tendency toward the figures at the absolute. Perhaps we should abandon any effort to seek for an absolute word and face the fact that it is all a matter of "how much?"—not of "yes" or "no."

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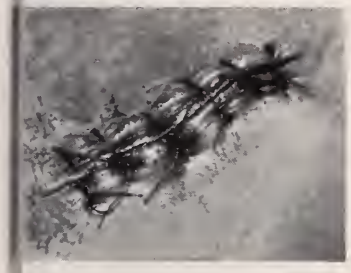
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Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (> 5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide,' check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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TRANSACTIONS

1973 House of Delegates

207th ANNUAL MEETING

The Medical Society of New Jersey

May 12-15, 1973



President William J. D'Elia



Incoming President Matthew E. Boylan



President D'Elia and Mrs. Boylan

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ANNUAL REPORTS

President

William J. D'Elia, M.D., Spring Lake
(Reference Committee "A")

In assuming the office of the President of The Medical Society of New Jersey, I embarked upon a year bearing responsibilities of immense proportion, certainly more diversified and far-reaching than one usually encounters. I am grateful for the opportunity to be involved in the initiation and implementation of so many important decisions and activities of the State Society. Not only are we concerned with the continued introduction of ever-increasing sophisticated methods and technics in the delivery of medical care, we are also confronted with the growing influence of third parties, fourth parties, fiscal intermediaries, and so on.

In an effort to improve communications and understanding throughout the Society the Presidents of Component Societies were regularly invited guests at the monthly Board of Trustees' meetings and enjoyed the opportunity of observing the business of the Society.

A Core Committee was organized to implement recommendations of the Board of Trustees for the development of the Foundation Approach to Health Care Evaluation. The Core Committee made an exhaustive study of existing foundations, including a direct-on-the-spot study of such organizations as the Foundation for Health Care Evaluation in Minneapolis, Minnesota. A Steering Committee followed, including representatives from each county society. Incorporation of the New Jersey Foundation for Medical Care Delivery is in progress, as well as the development of norms, carrier agreements, bylaws, peer review of all the complicated procedures of such a vast and important endeavor.

The Standing Committee on Medical Education has received from the AMA a one-year provisional approval for accreditation for courses in continuing physician education in New Jersey. The Committee is in the process of preparing the necessary application forms and assigning inspection teams for accreditation of courses throughout the State.

There were many important and constructive meetings conducted during the year in an attempt to develop broader avenues of approach and a closer communication and liaison. Conferences were held with allied health care professionals and State representatives, particularly the New Jersey Hospital Association, State Departments of Insurance, Health, Higher Education, State Board of Medical Examiners, and the New Jersey State Nurses' Association. A Joint Practice Committee with the New Jersey State Nurses' Association was established and a policy declaration developed with a clearer understanding of the status of the registered nurse in the delivery of health care.

The President headed the Medicaid Negotiating Committee, which met regularly with the Medical Director and staff of the Division of Medical Assistance and Health Services to arbitrate the myriad problems existing in the Medicaid Program.

During the year, we saw the Society conducting open hearings in each of the five Judicial Districts to ascertain from the members their thinking on various subjects, as mandated by adoption of Resolution 26 at the May, 1972, meeting of the House of Delegates. Items of extreme importance were presented for discussion. I regret to report that the participation of the membership left

much to be desired. An interim meeting of the House of Delegates was held in December, 1972, and I am sure that you all are familiar with the business and actions executed. The Society is confronted with many areas of concern, and I believe that we have embarked on a productive course.

We have changed the format of the Conference of Presidents and Presidents-Elect, and I am happy to report the response was gratifying with active participation and approval of most of the component societies.

During the year, I had occasion to visit many of the county societies, confer with many of the members and attempted to develop a closer relationship. There were visits with neighboring state medical societies. It should come as no surprise that our colleagues everywhere are beset with the same problems and just as concerned with the future status of the physician in the delivery of medical care.

Our Councils and Committees are continually involved in the business of the Society with an interest and dedication worthy of the praise and respect of every member. In an effort to shore up the functioning of the judicial mechanism, the Judicial Council held a conference workshop which was attended by the County Judicial Committee Chairmen, and the County Executive Secretaries. The Committee on Medical Defense and Insurance also held a program for the Chairmen of the County Medical Review and Advisory Committees to review the Society's Loss Control Program.

Every member should make a determined effort to become involved in the affairs of the State Society and to seek and stimulate the interest of non-members so that we may weld the physicians of New Jersey into a united group in order to face our problems head-on.

In this regard I have called for the establishment of a Health Care Council which will consist of the Presidents of the various professional organizations representing the providers of health care services.

I have sincerely enjoyed the past year and the experiences and associations I have had with the physicians of New Jersey. Your cooperation and assistance were willingly received and are deeply appreciated.

Filed with commendation to the President (page Tr 126)



President-Elect Rogers Incoming President Boylan President D'Elia

Secretary

Louis F. Albright, M.D., Spring Lake

(Reference Committee "A")

The office of the Secretary has continued its usual routines, primarily involving maintenance of membership records, correspondence, telephone inquiries, and completion of numerous questionnaires originating from various sources.

During the administrative year, the Secretary attended the clinical meeting of the American Medical Association in Cincinnati—serving in a dual role as MSNJ Secretary and an AMA Alternate Delegate. At state level, the Secretary attended the meetings of the Board of Trustees and the several committees of which he is chairman, member, or advisor.

Membership

(As of December 31, 1972)

Active: Paid	6,920	
Exempt	522	7,442*
Associate: Paid	559	
Exempt	62	621*
State Emeritus		301
Total of Above		8,364
State Honorary		8
New and Reinstated Members:		
Active	337	
Associate	359	696
Transfers within the state		17
Transfers out-of-state and resignations		86
Members deceased		120
Members dropped:		
Active (non-payment of dues)	44	
(N.J. licensure revoked)	2	
Associate (non-payment of dues)	19	65

AMA Membership

A total of 5,744 members of The Medical Society of New Jersey maintain active membership in the AMA. The Society's representation in the AMA House of Delegates continued to total six delegates—one for each thousand members, or fraction thereof.

Membership Directory

In October 1972, the completion of the 1972-73 edition of the *Membership Directory* was announced. Distribution to the entire membership was made the same month.

Basically the new *Directory* embodied the same features as those of the 1970-71 edition, which include:

The supplement section—available only in copies prepared for members—contains the Constitution and Bylaws of MSNJ, the AMA Principles of Medical Ethics, the Basic Concepts Underlying the Provision of Professional Medical Care, Legal Obligations Affecting Medical Practitioners, Guides for Physician-Hospital Relationships in New Jersey, and a list of Poison Control Centers in New Jersey.

Again, an expression of gratitude is in order for the cooperation received from the membership in assisting us to produce this *Directory*.

Filed (page Tr 126)

*Adjusted for transfers out-of-state, resignations, and deaths.

Treasurer

Samuel J. Lloyd, M.D., Trenton

(Reference Committee "B")

This 1973 interim financial report of your Treasurer has been prepared from the books and records of The Medical Society of New Jersey.

The Balance Sheet is presented as of March 31, 1973, and May 31, 1972. Figures at March 31, 1973 have not been audited, for the reason that the fiscal year of the Society does not end until May 31, 1973. The figures at May 31, 1972 have been abstracted from the report of audit dated June 23, 1972.

The Statement of Revenue, Expenditures, and General Surplus Unappropriated presents the transactions of the Society for the ten months ended March 31, 1973 and the year ended May 31, 1972.

Revenues have been examined on a test basis and disbursements have been test checked to approved supporting vouchers by the Society's independent accountants. The cash balances at March 31, 1973 were reconciled with the bank statements but were not confirmed directly with the depositories. Revenues from Counties for dues assessments were checked in detail to reports on file, but were not confirmed with County Treasurers at this time. Investments were not physically examined or confirmed at March 31, 1973.

These financial statements have been prepared in a form similar to the annual audit report, in order to show in greater detail the assets, liabilities, and fund balance, operating revenue and expenditures of the Society, in conformity with Resolution #28 approved by the 1968 House of Delegates under "Annual Financial Report."

BALANCE SHEET GENERAL FUND

Assets	March 31, 1973	May 31, 1972
Cash (Page Tr 12)	$ 28,985.84	$ 8,311.01
General Fund Investment Account (at cost) (Page Tr 13)	339,566.37	295,000.00
General Fund Saving Certificates (Page Tr 14)	45,000.00	45,000.00
General Fund Investment Portfolio (at cost) (Page Tr 14)	190,423.60	190,245.50
Accounts Receivable	7,657.17	10,332.36
Inventories (at cost)		
Maternity Service Record Books	836.40	1,643.28
"The Healing Art" Books	8,472.24	8,478.32
Land, Buildings and Equipment (at cost)	304,385.62	167,990.38
Deferred Expenses—Construction	90,000.00	—
Accrued Interest	5,828.38	6,054.86
Other Assets	1,700.17	695.49
Constrnction in Progress	—	13,169.00
	$1,022,855.79	$746,920.20

Liabilities and Fund Balances

Liabilities:		
Unexpended Budget Appropriations (Page Tr 10)	$ 144,619.86	—
Accounts Payable	4,419.59	44,335.35
Payroll Taxes Payable	1,224.43	455.05
Retained Reserve on Construction Contract	—	921.90
AMA Collection Fees Payable	299.20	2,907.67
American Medical Association	51,040.00	2,475.00
Due to Physicians' Relief Fund	38,280.64	36,750.00
Due to Medical Student Loan Fund	90,000.00	—
Deferred Income—Assessments Collected Applicable to Succeeding Year (Page Tr 12)	225,232.00	246,015.00
Funds for Specific Purposes:		
Annual Meeting	18,842.41	—
Construction Fund	—	40,450.00
House Restoration and Replacement	3,339.24	3,339.24
Land, Buildings and Equipment	304,385.62	167,990.38
Maternity Service Record Books	836.40	1,643.28
"The Healing Art" Books	8,472.24	8,478.32
Membership Directory	3,134.20	4,446.07
General Fund Balance (Unappropriated)	128,729.96	186,712.94
	$1,022,855.79	$746,920.20

Statement of Revenue, Expenditures and General Fund Balance (Unappropriated)

	Ten Months Ended March 31, 1973	Year Ended May 31, 1972
Revenue:		
Assessments Earned (Page Tr 12)	$435,095.00	$420,222.91
Interest Income from General Fund Investments (Page Tr 13)	6,083.58	8,626.32
Interest Income from General Fund Savings Certificates (Page Tr 14)	1,891.92	———
Interest Income From General Fund Investment Portfolio (Page Tr 14)	10,097.07	11,765.65
Maternity Service Record Book Sales	806.88	664.20
Miscellaneous Income	268.20	38.13
Total Revenue	$454,242.65	$441,317.21
Expenditures—Budget Appropriations (12 months)	$488,738.00	$392,145.17
Excess or (Deficit) of Revenue over Expenditures before Medical Journal Deficit, Transfers to Special Funds and Prior Year's Expenditures	($ 34,495.35)	$ 49,172.04
Adjustments and Transfers		
Medical Journal Deficit	$ 12,426.17	$ 30,689.68
Transfer to Annual Meeting Special Fund	———	19,714.29
Prior Year's Expenditures Paid in Current Years	6,038.12	———
	$ 18,464.29	$ 50,403.97
Net Decrease in Fund Balance	($ 52,959.64)	($ 1,231.93)
General Fund Balance (Unappropriated):		
Balance, Beginning	$186,712.94	$237,944.87
	$133,753.30	$236,712.94
Transfers from General Fund (Unappropriated)	($ 5,023.34)	($ 50,000.00)
Balance, Ending	$128,729.96	$186,712.94

Statement of Expenditures—General Fund
For the Ten Months Ended March 31, 1973

Account	Adopted Budget	Total Expended	Balance Unexpended
Executive Salaries	$ 82,132.00	$ 70,352.86	$ 11,779.14
General Staff Salaries	135,759.81	112,025.05	23,734.76
General Executive Office Expenses	21,000.00	17,843.08	3,156.92
Executive Travel	3,950.00	3,597.17	352.83
House Maintenance	25,600.00	18,097.37	7,502.63
Treasurer	7,600.00	6,231.73	1,368.27
Finance and Budget Committee	75.00	.32	74.68
Secretary	400.00	———	400.00
Salary Taxes	12,766.19	9,011.59	3,754.60
Insurance	11,055.00	10,024.89	1,030.11
House Reserve	15,600.00	16,280.46	(680.46)
MSNJ Pension Plan	1,600.00	1,310.88	289.12
MSNJ Building Loan	14,000.00	2,377.52	11,622.48
Legislation Council	8,400.00	4,277.60	4,122.40
Council on Public Health	2,700.00	994.64	1,705.36
Council on Public Relations	9,400.00	6,720.53	2,679.47
Council on Medical Services	700.00	33.64	666.36
Council on Mental Health	1,600.00	322.77	1,277.23
President & Presidential Officers	15,750.00	3,979.91	11,770.09
AMA Delegates	16,600.00	12,428.04	4,171.96
Woman's Auxiliary	6,650.00	6,215.93	434.07
Committee on Medical Education	35,800.00	130.66	35,669.34
Conference Groups	500.00	———	500.00
Membership Directory	17,000.00	17,000.00	———
Committee on Emergency Medical Care	300.00	157.72	142.28
Credentials & Membership Committee	900.00	784.10	115.90
Archives & History	100.00	———	100.00
Project Hope—Vietnam	6,000.00	———	6,000.00
Committee on Medical Defense and Insurance	500.00	120.18	379.82
Board of Trustees	7,000.00	2,502.88	4,497.12
Contingent	10,000.00	7,349.02	2,650.98
Judicial Council	500.00	78.48	421.52
Legal	7,300.00	4,631.98	2,668.02
Medical Student Loan Fund	6,000.00	6,000.00	———
Authorized Reimbursement for Representatives to Meetings	3,500.00	3,237.14	262.86
Total Budget Expenditures	$488,738.00	$344,118.14	$144,619.86

Balance Sheet
Physicians' Relief Fund

Assets	Ten Months Ended March 31, 1973	Year Ended May 31, 1972
Due from General Fund	$38,280.64	$36,750.00
Fund Balance	$38,280.64	$36,750.00

Statement of Revenue and Fund Balance
Physicians' Relief Fund

	Ten Months Ended March 31, 1973	Year Ended May 31, 1972
Revenue:		
Transfer from General Fund	$ —	$35,000.00
Income from Certificate of Deposit	$ 1,530.64	$ 1,750.00
Total Revenue	$ 1,530.64	$36,750.00
Fund Balance, Beginning	$36,750.00	$ —
Fund Balance, Ending	$38,280.64	$36,750.00

Statement of Revenue and Expenditures
Medical Journal

	Ten Months Ended March 31, 1973	Year Ended May 31, 1972
Revenue:		
Members' Subscriptions Earned (Page Tr 12)	$21,115.50	$ ———
Advertising:		
State Medical Journal Advertising Bureau	29,766.17	46,652.03
Local	11,905.00	13,096.37
Cooperative Rebate	2,571.99	1,731.34
Classified	248.30	614.50
Subscriptions and Extra Copies	1,909.56	1,491.36
Reprints—Net	1,874.02	440.35
Illustrations	———	568.96
Total Revenue	$69,390.54	$64,594.91
Expenditures:		
Publication	$53,776.29	$61,108.36
Salaries	15,440.46	18,000.00
Advertising Manager's Commission	5,017.30	6,479.90
Commissions—Local	5,087.00	4,190.06
Discounts	776.82	1,100.61
Administrative Expenses	———	1,300.10
Payroll Taxes	844.93	982.95
Insurance	315.64	312.28
Travel	———	541.52
Illustration Expense	282.47	1,088.70
Office Expenses	———	69.11
Bad Debts	275.80	111.00
Total Expenditures	$81,816.71	$95,284.59
Excess of Expenditures over Revenue	$12,426.17	$30,689.68

Balance Sheet
Medical Student Loan Fund

Assets	Ten Months Ended March 31, 1973	Year Ended May 31, 1972
Cash (Page Tr 12)	$ 13,251.37	$ 16,414.33
Certificates of Deposit and Savings Accounts (Page Tr 14)	$ 95,000.00	$160,000.00
Notes Receivable—Secured by Life Insurance Policies	$201,309.00	$195,709.00
Accrued Interest	$ 3,124.07	$ 1,019.21
Loans Receivable—General Fund	$ 90,000.00	$ ——
Fund Balance	$402,684.44	$373,142.54

Note: The fund balance includes $6,862.00 designated as the Albert Barker Kump Memorial Grant and $5,055.00 designated as the Joseph E. Mott Memorial Grant.

Statement of Revenue and Fund Balance
Medical Student Loan Fund

Revenue: Contributions:	Ten Months Ended March 31, 1973	Year Ended May 31, 1972
General	$ 15,367.87	$ 7,166.60
Albert Barker Kump Memorial Grant	250.00	300.00
Joseph E. Mott Memorial Grant	———	25.00
General Fund Contribution	6,000.00	———
Interest on Savings Account and Certificates of Deposit	5,206.88	6,507.87
Income from Investments	———	1,159.60
Interest on Notes Receivable	199.63	553.02
Interest on Loan to General Fund	2,377.52	———
Total Revenue	$ 29,401.90	$ 15,712.09
Bad Debt Recovery (Expense)	140.00	(60.00)
Net Revenue	$ 29,541.90	$ 15,652.09
Fund Balance, Beginning	$373,142.54	$357,490.45
Fund Balance, Ending	$402,684.44	$373,142.54

Schedule of State Assessments Collected
For the Ten Months Ended March 31, 1973

County	1973 Dues	1972 Dues	Net State Assessments
Atlantic	$ 9,170.00	$ 510.00	$ 9,680.00
Bergen	55,720.00	2,700.00	58,420.00
Burlington	12,390.00	720.00	13,110.00
Camden	26,040.00	510.00	26,550.00
Cape May	2,450.00	——	2,450.00
Cumberland	6,790.00	210.00	7,000.00
Essex	91,070.00	3,450.00	94,520.00
Gloucester	7,000.00	——	7,000.00
Hudson	14,000.00	3,570.00	17,570.00
Hunterdon	——	480.00	480.00
Mercer	15,400.00	8,520.00	23,920.00
Middlesex	28,280.00	630.00	28,910.00
Monmouth	23,450.00	1,860.00	25,310.00
Morris	25,620.00	1,260.00	26,880.00
Ocean	7,840.00	1,290.00	9,130.00
Passaic	39,900.00	420.00	40,320.00
Salem	140.00	——	140.00
Somerset	6,370.00	1,140.00	7,510.00
Sussex	2,800.00	300.00	3,100.00
Union	44,450.00	450.00	44,900.00
Warren	3,430.00	180.00	3,610.00
Total	$422,310.00	$28,200.00	$450,510.00

Reconciliation of State Assessment Account
For the Ten Months Ended March 31, 1973

Unearned Assessments, May 31, 1972	$246,015.00
Collections, Net of Refunds:	
Members and Associate Dues per above	450,510.00
	$696,525.00
Less 1973 assessments applicable to year ending May 31, 1974 ($422,310.00 less $36,198.00 for Subscription and Annual Meeting assessments x 7/12)	$225,232.00
Earned Assessments for the ten months ended March 31, 1973	$471,293.00

Analysis of Earned Assessments
For the Ten Months Ended March 31, 1973

Regular and Associate Assessments	$435,095.00
Members' Subscriptions Assessments	21,115.50
Annual Meeting Assessments	75,082.50
Total Earned Assessments	$471,293.00

Analysis of Cash, Certificates of Deposit, Investments and Income Thereon
March 31, 1973

General Fund:		
New Jersey National Bank:		
Treasurer's General Checking	$ 13,985.84	
Executive Account Checking	14,500.00	
Office Petty Cash Fund	500.00	
Total		$28,985.84
Medical Student Loan Fund:		
New Jersey National Bank:		
Treasurer's Checking Account		$13,251.37

SCHEDULE OF SPECIAL ASSESSMENTS COLLECTED
For the Ten Months Ended March 31, 1973

County	American Medical Association Dues
Atlantic	$ 13,530.00
Bergen	55,440.00
Burlington	15,950.00
Camden	36,025.00
Cape May	3,520.00
Cumberland	6,820.00
Essex	103,730.00
Gloucester	9,570.00
Hudson	25,300.00
Hunterdon	220.00
Mercer	30,690.00
Middlesex	33,660.00
Monmouth	16,720.00
Morris	29,810.00
Ocean	7,590.00
Passaic	29,920.00
Salem	— — —
Somerset	6,985.00
Sussex	2,530.00
Union	54,230.00
Warren	4,730.00
Total	$486,970.00

RECONCILIATION OF SPECIAL ASSESSMENTS
For the Ten Months Ended March 31, 1973

	American Medical Association
Balance Payable, May 31, 1972	$ 2,475.00
Assessments collected per above	486,970.00
	$489,445.00
Remitted to AMA	438,405.00
Balance Payable, March 31, 1973	$ 51,040.00

ANALYSIS OF GENERAL FUND INVESTMENTS AND INCOME THEREON
March 31, 1973

New Jersey National Bank: Certificate of Deposits	Due Date	Cost	Maturity Value	Yield	Interest Income
#71170	4/27/73	$ 30,000.00	$ 30,000.00	5 %	$1,254.44
#73940	4/13/73	70,000.00	70,000.00	5 %	727.50
#73942	4/20/73	35,000.00	35,000.00	5 %	363.75
U.S. Treasury Bill	7/31/73	34,028.75	35,000.00	5.55%	323.80
	7/5/73	34,161.56	35,000.00	5.6 %	335.36
	6/14/73	34,412.58	35,000.00	5.3 %	147.00
	8/28/73	33,961.47	35,000.00	5.45%	222.54
	8/30/73	33,991.81	35,000.00	6.1 %	168.15
	8/30/73	34,010.20	35,000.00	6.06%	166.63
Income from Investments redeemed during period					3,905.05
Total		$339,566.37	$345,000.00		$7,614.22
Less Interest Income on Physicians' Relief Fund					1,530.64
General Fund Investment Income					$6,083.58

Analysis of General Fund Savings Certificates and Income Thereon
March 31,1973

	Cost	Rate of Interest	Interest Income
New Jersey National Bank			
Certificate Number 56213	$15,000.00	5 %	$ 628.88
First National Bank of Spring Lake			
Certificate Number 1242	15,000.00	5½%	638.02
South Jersey National Bank			
Certificate Number 2101	15,000.00	5 %	625.02
Total	$45,000.00		
General Fund Savings Certificate Income			$1,891.92

Schedule of Investment Portfolio and Income Earned
March 31, 1973

Description	Due Date	Yield to Maturity	Cost	Maturity Value	Interest Income
Fed. Nat'l. Mortgage Assoc.	6/12/73	6.75%	$ 49,937.50	$ 50,000.00	$ 2,811.38
Fed. Nat'l. Mortgage Assoc.	12/10/74	6.1 %	20,000.00	20,000.00	1,016.26
Fed. Nat'l. Mortgage Assoc.	6/10/75	5.25%	20,000.00	20,000.00	874.65
Fed. Nat'l. Mortgage Assoc.	3/11/74	5.34%	19,883.80	20,000.00	133.50
Export-Import Bank					
Debenture	4/30/73	6.15%	20,000.00	20,000.00	1,022.50
Union Pacific Railroad					
Equipment Trust Cert.	2/01/74	7.00%	20,843.00	20,000.00	1,166.20
Federal Intermediate					
Credit Bank	10/01/74	5.7%	20,026.80	20,000.00	225.00
U.S. Treasury Bill	6/07/73	5.3%	19,732.50	20,000.00	89.18
Total Investments			$190,423.60	$190,000.00	
Income from Investments redeemed during period					2,758.40
Total Interest Income from Investment Portfolio					$10,097.07

Analysis of Medical Student Loan Fund Investment Account and Income Thereon
March 31, 1973

New Jersey National Bank: Certificates of Deposit	Due Date	Cost	Rate of Interest	Interest Income
66334	4/21/73	$30,000.00	5%	$1,257.64
66385	6/18/73	20,000.00	5%	838.68
71167	4/20/73	5,000.00	5%	209.61
73272	4/20/73	15,000.00	5%	534.37
73946	4/25/73	10,000.00	5%	83.33
Savings Account				
11-131102		15,000.00	4¼%	569.82
Total Investments		$95.000.00		
Income from Investments redeemed during period				1,713.43
Total Interest from Investments				$5,206.68

Filed with commendation to the Treasurer (page Tr 128)

Board of Trustees

A. Guy Campo, M.D., Chairman, Westville
(Reference Committee "A")

Full minutes of the meetings of the Board of Trustees have been distributed to component societies, and summaries of its significant actions have been highlighted in *The Journal.* Therefore, as has been the custom, this report of the Board of Trustees will cover only those items of particular significance that are not reflected elsewhere in the individual reports of councils and committees.

The Society's business continues to make heavy demands upon the time of the Trustees. Since its last report to the House, a total of 10 meetings of the Board will have been held. Attendance of members is excellent. Doctor David Eckstein of Trenton was elected by the Board to serve as Secretary during 1972-73. Commendation is due him for his conscientious performance in processing all Board correspondence and meeting notices.

Routinely, the Board has dealt with matters of all kinds arising out of its responsibilities or brought to its attention, including correspondence from members, component societies, the AMA, and outside organizations. It has appointed representatives to local, state, and national meetings of concern to MSNJ; acted on reports and recommendations of the Society's councils and committees; and cooperated with allied organizations and various departments of state government.

The Board recorded its profound grief in the death of Luke A. Mulligan, M.D., who rendered splendid service to The Medical Society of New Jersey as member and chairman of the Board of Trustees, chairman of the Committee on Medical Student Loan Fund and of the Committee on Medicine and Religion, and Delegate to the American Medical Association.

There will be two more meetings of the Board before the first session of the House of Delegates. The items from those meetings which must be directed to your attention will be the subject of a supplemental report to the House.

Filed (page Tr 126)

Ad Hoc Committee to Investigate the Nominating Procedure

(Reference Committee "A")

In 1972 Reference Committee "A" recommended, and the House approved, that resolution #4 (Nominating Procedure) be not adopted, but that it be referred to the Board of Trustees with the request that the Board establish an *ad hoc* committee to investigate the entire matter and report back to the House of Delegates at the 207th Annual Meeting.

Meeting on May 9, 1972, the Board directed that the President be empowered to establish an *Ad Hoc* Committee to Investigate the Nominating Procedure and to appoint the Committee's personnel. The following Committee was appointed by the President:

Louis F. Albright, M.D., Chairman
Hillel M. Ben-Asher, M.D.
Sherman Garrison, M.D.
Vincent H. Gillson, M.D.
Raymond A. McCormack, Jr., M.D.

The Committee met on January 10, 1973, to discuss resolution #4 as follows:

Whereas, the Nominating Committee is one of the most vital committees of the Society; and

Whereas, under current usages, nomination for office by this Committee virtually assures election; and

Whereas, the Nominating Committee does not always have full knowledge of the candidates' ability and performance; and

Whereas, the House of Delegates is expected to ratify the Nominating Committee's report also without full knowledge of the candidates; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey require the following:

(1) All candidates for elective office and Delegates to the AMA be identified not later than March 31 of any fiscal year.

(2) The names of these candidates and their resumes be included in the House of Delegates Convention Manual.

(3) No member of the Nominating Committee shall serve more than three consecutive years.

(4) The Committee on Revision of Constitution and Bylaws shall be instructed to study the nominating and election procedure with a view toward achieving maximal involvement of our membership, and report its recommendations at the next annual meeting of the House of Delegates.

The Committee discussed the four items contained in the "Resolved" portion of the resolution as follows:

Items #1 *and* #2—It was pointed out that the motivating force behind this resolution was probably the desire of the delegates to have more information on candidates running for office.

Recommendation

That all candidates for office to be dealt with by the Nominating Committee be identified as candidates for the specific offices by official communication to the Secretary of MSNJ submitted no later than March 31, together with completed informational data sheets which will be supplied in advance by the Secretary to secretaries of all component societies. This procedure will not affect nominations from the floor.

Approved (page Tr 126)

The Committee noted that in order to afford the county societies enough time to have the informational data sheets completed and returned to the Executive Offices by the March 31 deadline, they should be mailed to secretaries of component societies well in advance. In January of each year, a list of offices to be filled by election is sent to secretaries of component societies with copies to executive secretaries. The Committee was unanimous in its opinion that if the House of Delegates approves the foregoing recommendation, the informational data sheets should be included in this January mailing.

The Committee was also of the opinion that the foregoing procedure, if adopted, might possibly result in an enormous amount of paper work and that the desired outcome might not result.

Recommendation

That the Board of Trustees review the procedure in terms of its practicability and usefulness and report thereon to the House of Delegates after the first year of operation.

Approved (page Tr 126)

Item #3—The Committee discussed item #3 extensively. Comment was made that this was a matter of deciding whether or not to restrict the rights of the component societies. Doctors Albright and McCormack were of the opinion that the limitation of the length of membership on the Nominating Committee is the right of the component society. Doctors Ben-Asher and Gillson felt that there should be a limitation, however, not necessarily the three years mentioned in item #3.

Recommendation

That this item be referred back to the House of Delegates for definite determination as to whether or not a change should be made concerning the terms of office on the Nominating Committee and, specifically, the number of terms permitted. If such a determination for change is made, this item should be referred to the Standing Committee on Revision of Constitution and Bylaws for preparation and introduction of the proper Bylaw amendment.

Approved with notation (page Tr 126)

Item #4—In view of the function of this *Ad Hoc* Committee, and in view of the fact that the House had before it this resolution, which it chose in its wisdom not to adopt, the Committee feels that item #4 has no relevance to the work of the Committee. Therefore, the Committee voted not to take a position with reference to item #4. Additionally, the Committee felt that the implementation of Recommendation #1 achieves to some extent the principal objective of item #4.

In connection with the foregoing, the Committee points out that in its opinion item #4 of the "Resolved" assigned to the Standing Committee on Revision of Constitution and Bylaws is a function beyond its proper purview. According to the Bylaws—Chapter 9, Section 19 (b)— "The committee (on Revision of Constitution and Bylaws) shall be responsible for preparing and/or evaluating proposed revisions to the Constitution and/or Bylaws, and for properly submitting them to the House of Delegates."

This section apparently does not empower the Committee on Revision of Constitution and Bylaws to suggest changes in the Constitution and Bylaws, but only to evaluate proposed changes and/or to couch the proposed changes in effective language to accomplish the agreed-upon amendments.

The Committee felt that in order to acquaint the alternate members of the Nominating Committee with the nominating procedure, the alternate members should be permitted to attend the meetings of the Nominating Committee.

Recommendation

That the House of Delegates approve the granting of permission to alternate members to attend the meetings of the Nominating Committee without the privilege of voice or vote.

Approved (page Tr 126)

Joint Conference of Presidents and Presidents-Elect of Component Societies

(Reference Committee "A")

Once again the Board continued its precedent of sponsoring conferences for presidents and presidents-elect of component societies. The fall conference was held on Sunday, October 15, 1972. A total of 24 presidents, presidents-elect, and other officers represented 20 component societies.

As an experimental innovation, the Executive Committee of the Board of Trustees offered a new format for the spring conference, which was held on March 18, 1973. A total of 22 presidents, presidents-elect, and other officers represented 16 component societies.

The morning program included a series of speakers from among the Society's officers and council and committee chairmen, who addressed the conference group and answered questions on significant programs and policies of MSNJ. Following luncheon, the group met, as in the past, with the Board of Trustees. Gustav L. Ibranyi, M.D., who served as Chairman of the conference, indicated that the conferees found the new format to be informative and urged its continuance.

Filed (page Tr 126)

Joint Practice Committee with the New Jersey State Nurses' Association

(Reference Committee "A")

On July 16, 1972, the Board authorized the establishment of a Joint Practice Committee with the New Jersey State Nurses' Association geared to the clarification and increased collaboration of medical-nursing roles.

At its March meeting, the Board adopted the following policy declaration of the Joint Practice Committee:

The Medical profession has long regarded the registered nurse as the licensed physician's primary colleague and associate in preventing and treating illnesses and injuries and in maintaining health. With this in mind, the Joint Practice Committee of The Medical Society of New Jersey and the New Jersey State Nurses' Association hereby issues the following declaration of policy:

The medical and nursing staffs of all hospitals and other agencies and institutions utilizing the services of nurses are urged to develop in a cooperative spirit a program expanding the role of the nurse.

1. Consideration is to be given to the formulation of a plan recognizing the diversified professional capabilities of the registered nurse.

The granting of expanded professional privileges should follow completion of formalized educational programs and demonstrated increased professional competence.

2. All such programs are to be supported by sound clinical experience.

Although recognizing the need for establishing educational programs in specialized clinical fields, proper and continuing emphasis should be placed upon

evaluating the levels of competence of generalized nursing practice.

Filed (page Tr 126)

Liberalization of Abortion Laws
(Reference Committee "A")

The 1972 House of Delegates adopted a resolution recommending liberalization of the State's abortion laws. A copy of the resolution, as adopted, was forwarded to the Governor, President of the Senate, and Speaker of the General Assembly in May.

Replying in November the Governor stated: "As you know, a trial court has found the New Jersey abortion laws to be unconstitutional. The question of constitutionality must be determined by an appellate court either in New Jersey or in the federal system. This case is presently before the appellate courts. As a result, no action should be taken at this time on any abortion legislation until the question of the constitutionality of the New Jersey abortion laws has been finally determined."

At its February 18 meeting, the Board reaffirmed an earlier policy decision sanctioning abortions with certain restrictions.

In a memorandum to its members the Board advised physicians to be guided by the official interpretation of the recent decision by the U.S. Supreme Court on the subject.

The 1972 House of Delegates adopted a resolution approving abortion, but urged the adoption of state legislation that would set forth the following requirements:

1. There be no restriction upon the performance of abortion up to the end of the 16th week from commencement of pregnancy, except those of good, safe, medical practice.

2. That the requirements for the performance of abortion be: (1) that the pregnant woman gives her consent; (2) that, if married, her husband either concur, or sign a release; (3) that her physician agree that her health would safely permit it, or state that her physical or mental health requires it.

3. A pregnant woman, age 18 or over, should not be required to obtain parental or guardian consent for abortion.

4. Pregnant girls under age 18 should have parental or guardian consent for abortion.

5. Abortions should be performed only in those areas of hospitals where adequate surgical practice can be assured by competent medical personnel.

6. No physician shall be required to perform an abortion, nor shall any institution be required to allow an abortion to be performed within its walls.

7. No physician or medical institution can be declared liable for having performed an abortion provided that appropriate written permission was obtained and the procedure was done according to accepted standards.

8. No abortion shall be permitted in New Jersey on any woman who is not a bona fide resident of the state.

9. No advertising or solicitation of patients for abortions, by direct or indirect methods, in or outside the State of New Jersey, shall be permitted.

Filed (page Tr 126)

Special Session of MSNJ House of Delegates
(Reference Committee "A")

Three hundred delegates, fellows, and officers of The Medical Society of New Jersey participated in a special session of the House of Delegates held on Sunday, December 10, 1973.

The session was called in consequence of adoption of resolution #26 (Union County) by the House of Delegates at the 206th Annual Meeting last May. That resolution empowered the Council on Public Relations "to conduct a survey, which shall include open hearings in each of the five judicial districts, to ascertain from the members their thinking on the subjects of: (1) formation of a medical union; (2) implementation of an articulate, aggressive public relations program; (3) the function of JEMPAC; and (4) other pertinent subjects for the benefit of members of MSNJ . . . and report its findings to a special session of the House of Delegates in the fall of 1972."

Hearings were held, with the following percentages of members of the five districts in attendance: first—2.4; second—0.9; third—1.5; fourth—2.0; and fifth—4.0. The over-all average was 2.16 per cent. Survey ballots were mailed on October 16 to 8,226 members; 2,609 were returned, for a percentage of 31.7.

Significant results of the ballot, in summary, were as follows; 1,696 indicated their interest in the establishment of a union or guild for purposes of negotiations; 1,700 indicated approval of the establishment of a foundation; 795 indicated approval of the establishment of HMO's, but 1,533 voted to disapprove such establishment; 1,089 approved the prompt establishment of an articulate and aggressive public relations program, supported by an annual budget of up to $15 per capita.

The House received the full report of the hearings and the survey, submitted by the Chairman of the Council on Public Relations, and then took the following actions.:

1. Considered and protractedly debated a resolution submitted by a delegate from Union County, which, as finally amended, read:

Whereas, by directive of the House of Delegates of The Medical Society of New Jersey in session—May 1972— an inquiry was conducted as to the sentiment of its membership re the formation of a medical guild or union; and

Whereas, the inquiry conducted by the Society supported this concept; now therefore be it

RESOLVED, that The Medical Society of New Jersey cooperate in the formation of a Physicians' Guild.

By a standing tally of 167 to 108, the House voted to reject the resolution.

2. The House next turned its attention to the subject of the establishment of The Medical Society of New Jersey Foundation for Health Care Evaluation. The matter was brought to focus in a resolution introduced by the Society's Core Committee on the Foundation Approach to Medical Care, which resolution was lengthily discussed and twice amended from the floor. In final form it reads:

Whereas, The Medical Society of New Jersey recognizes that the cost and availability of health care services as well as the quality thereof are matters of vital concern to both the public and the medical profession; and

Whereas, the need for a systematic and comprehensive peer review system has been clearly established in the State of New Jersey; and

Whereas, the passage of H.R. 1 requires at least one Professional Standards Review Organization be established in each state pursuant to the administration of the Medicare and Medicaid programs; and

Whereas, this recently enacted law provides that organizations founded by physicians are to be given first consideration as Professional Standards Review Organizations by the Secretary of HEW; and

Whereas, after January 1, 1976, the Secretary of HEW may designate other organizations within a given state, such as state agencies, fiscal intermediaries, or insurance carriers to assume the Professional Standards Review Organization function when physician organizations are unwilling or unable to serve in such capacity; now therefore be it

RESOLVED, that The Medical Society of New Jersey proceed with all deliberate speed to establish as a separate corporate entity, a New Jersey Foundation For Health Care Evaluation, to which all physicians licensed to practice in New Jersey may belong and in which membership is voluntary; and be it further

RESOLVED, that as soon as the Foundation is organized it shall begin negotiations with the Secretary of HEW for recognition as the Professional Standards Review Organization for the State of New Jersey; and be it further

RESOLVED, that as a requirement for consideration of problems all insurance carriers and third parties be obligated to accept the rulings of this Foundation in reference to decisions on health care evaluation and usual and customary fees for service.

By voice vote the House adopted the resolution, as amended.

3. On the basis of a resolution introduced by the Essex County Medical Society, the House next gave consideration to the establishment of a membership inquiry and complaint mechanism. This resolution, too, was amended from the floor, and in final version reads:

Whereas, it is evident from the membership hearings that many speaking for unionism of the profession do not desire unionism's (1) forced conformity, (2) high dues or assessments, (3) strikes or secondary boycotts, and (4) problems of public resentment; and

Whereas, it is also evident from the hearings that there is membership dissatisfaction in their daily problems involving third party carriers and government medical programs; and

Whereas, the solution of these problems could easily fit into the structure of organized medicine at the State level; now therefore be it

RESOLVED, that The Medical Society of New Jersey establish a membership inquiry and complaint mechanism as follows:

(1) Four specific committees be activated to meet directly with representatives of respective carriers or intermediaries on a routine monthly basis and that these committees be Medicare, Medicaid, Blue-Shield and a committee for other health insurance carriers. These committees to be comprised of at least one member from each judicial district.

(2) That a post office box be established through The Medical Society of New Jersey to specifically receive membership complaints for sorting and immediate transmittal to the proper committee.

(3) That a form for third party membership complaints be adopted and published as a full page in *The Journal* of The Medical Society of New Jersey and that county societies be requested to publish like forms in their bulletins.

(4) That members be informed promptly in writing of the disposition of their complaints or inquiries.

(5) That the State complaint mechanism be coordinated with and cooperate with, and receive inquiries and complaints from similar county medical society inquiry and complaint mechanisms where they exist.

(6) That The Medical Society of New Jersey or the county peer review committee refuse to hear complaints, unless the carriers agree to be bound by the decision of the committee.

After extensive discussion, by a voice vote the House strongly indicated its decision to adopt the resolution, as amended.

4. As its final action, the House adopted the following resolution, presented from the floor by the Chairman of the Council on Public Relations, Howard D. Slobodien, M.D.:

RESOLVED, that the Council on Public Relations develop promptly an articulate, aggressive public relations program, to be supported by an annual budget of up to $15 per capita.

Filed (page Tr 126)

Survey of Methods to Increase AMA Membership
(Reference Committee "A")

In early June, the Secretary of the Board of Trustees sent a memorandum to secretaries of component societies calling attention to resolution #6, "Survey of Methods to Increase AMA Membership," which was adopted by the House in 1972.

Component societies were asked to cooperate in the implementation of the resolution. The information garnered by the component societies from their membership, with reference to "proposals for new mechanisms of activities that will revitalize interest," or any other relevant data called for by the resolution, should be reported to the State Society within six months.

To date MSNJ has not received any reports from the component societies. However, county bulletins indicate that AMA membership is being stimulated at the local level.

Filed (page Tr 126)

Licensure by Endorsement for Diplomates of Specialty Boards
(Reference Committee "D")

Last May, the House of Delegates adopted resolution #12, which called upon MSNJ most strongly to urge the New Jersey State Board of Medical Examiners to adopt amendments to its rules, or seek remedial legislation, if necessary, to provide for the licensing by endorsement, of specialty board diplomates without discrimination between graduates of foreign medical schools and those of United States or Canadian medical schools.

On May 10, 1972, the Stae Board of Medical Examiners adopted the following ruling (N.J.A.C. 13:35-4.1):

The Board shall grant without examination a license to practice medicine and surgery to any person who shall furnish proof that he can fulfill the requirements demanded in N.J.S.A. 45:9-1 et seq. relating to applicants for admission by examination, and furthermore provide with the application satisfactory evidence that he is a physician who has been licensed to practice medicine and surgery in a sister state, and is a diplomate of any of the specialty boards approved by the American Medical Association or the American Osteopathic Association.

Filed (page Tr 131)

Drug Abuse Registry
(Reference Committee "F")

On the recommendation of Reference Committee "F", the 1972 House of Delegates adopted resolution #17, which called upon MSNJ to work with the New Jersey Department of Health to effect a change in the Department's regulations, so that reports to the Department on drug abusers and addicts no longer must include their full names, addresses, and Social Security numbers.

In implementation of that action of the House, the resolution was referred to the

Commissioner of Health and the Director of the Division of Narcotic and Drug Abuse Control of New Jersey.

Filed (page Tr 133)

Establishment of a Membership Inquiry and Complaint Mechanism

(Reference Committee "F")

The Board of Trustees, at its meeting on December 17, 1972, referred to the Executive Committee, for implementation, the resolution from the Special Session of the House of Delegates calling for the establishment of a membership inquiry and complaint mechanism.

In compliance with the Board's directive, the Executive Committee appointed the following committees:

Membership Inquiry and Complaint Committee with Medical-Surgical Plan of New Jersey

Samuel Baum, M.D., Passaic
Donald P. Burt, M.D., Morristown
Arthur C. Dietrick, M.D., Mount Holly
Karl T. Franzoni, M.D., Trenton
James E. George, M.D., Westville

Membership Inquiry and Complaint Committee with Medicare

Alfred A. Alessi, M.D., Oradell
William H. Coleman, M.D., Trenton
Richard H. DuPree, M.D., Woodbury
Andrew G. Hudacek, M.D., Morristown
Joseph W. Schauer, Jr., M.D., Farmingdale

Membership Inquiry and Complaint Committee with Medicaid

John J. Crosby, Jr., M.D., Jersey City
Michael J. Doyle, M.D., Neptune
Armando F. Goracci, M.D., Woodbury
Frederick J. Knocke, M.D., Readington
Robert E. McNamara, M.D., Newark

Membership Inquiry and Complaint Committee with Other Health Insurance Carriers

Melvin J. Andrews, M.D., Cherry Hill
David R. Brewer, Jr., M.D., Woodbury
Emanuel M. Satulsky, M.D., Elizabeth
Howard D. Slobodien, M.D., Perth Amboy
Robert A. Weinstein, M.D., Newton

Filed (page Tr 133)

Improper Denial of Physicians' Claims Under Medicaid

(Reference Committee "F")

Last year, the House of Delegates adopted resolution #18 (Improper Denial of Physicians' Claims Under Medicaid) which directed that a copy of the resolution be forwarded to the Commissioner of the New Jersey Department of Institutions and Agencies. Commissioner Robert L. Clifford has replied as follows:

"After carefully reviewing this resolution and provisions in the Health Services Act (Chapter 413, Laws of 1968), I am unable to reconcile the statement that Medicaid's action as forwarded in Health Services Program Staff Bulletin S-01.3a 'abrogates the intent' of the Act. On the contrary, the administrative ruling on physicians' claims payment in hospital denials appears to me to be clearly consistent with the requirements of the Act, with specific reference to Section 12, page 10.

It was never the intent of the ruling to violate in any way the patient-physician relationship or the contractual rights between them, as stated in the resolution; nor was the ruling enacted as an 'arbitrary or capricious' measure but was carefully and thoughtfully conceived over a period of months.

As you may be aware, having seen S-01.3a, a hospital claims review system went into effect last year with the intent of determining whether a recipient's hospitalization was, in fact, medically necessary and within Medicaid's regulations. The provider manual clearly spells out the criteria for excluded services.

Since that time, hundreds of hospital claims have been denied, totaling hundreds of thousands of dollars, and each of these claims were denied because (1) the service was not allowed under Medicaid (e.g., obesity treatments), (2) could have been just as easily performed on an outpatient basis without affecting the patient, or (3) the hospitalization period exceeded the authorized days when there was no request for reauthorization of added days, among the most common causes for denials.

When these kinds of mis-utilization of costly hospitalization occurred, they did not necessarily occur at the initiation of the hospital but generally on the recommendation and advice of an attending physician. Therefore, logic and fairness would have to dictate that if a *non-reimbursable* hospital stay is recommended and the length of stay is controlled by an attending physician, both the hospital and the physician bear the responsibility equally, and neither are entitled to reimbursement.

We recognize, of course, that there are occasions when a patient's stay may be unnecessarily extended through no fault of the attending physician, based on any number of variables. When this occurs and when the physician feels that he has been wrongfully denied payment, he may appeal to the Director, Division of Medical Assistance and Health Services, and may, if necessary, seek a Fair Hearing.

I sincerely hope that this letter has helped in some way to clarify the Department's position on this apparently sensitive issue. I feel confident that once you recognize this position as being not only consistent with the law in protecting public monies but also a logical and responsible method of carrying out this public trust, you will, I know, be better able to appreciate and sympathize with our necessary stand."

Filed (page Tr 133)

Pilot Pediatric Nurse Practitioner Program in New Jersey
(Reference Committee "F")

The Board of Trustees, at its September 17 meeting, considered a request that it grant approval to the Pediatric Nurse Practitioner Program of the Department of Community Medicine of the College of Medicine and Dentistry of New Jersey, developed jointly by the Rutgers Medical School and the Rutgers University College of Nursing. This program is a pilot project concerned with the establishment of a Pediatric Nurse Practitioner Program to utilize better the professional nurse as a source of manpower in the delivery of primary health care services to children and their families. It is intended that the program will prepare the nurse to function in an expanded role and to assume some of the responsibilities inherent in providing quality health care to infants and children traditionally performed by physicians. It is designed to prepare both the registered nurse who is employed in child health settings as well as the nurse who is currently inactive. Applicants to the program must be registered nurses licensed in the State of New Jersey. A baccalaureate degree in nursing is recommended but not mandatory.

The Board voted to record itself as of the opinion that the program as proposed is fundamentally sound. However, the Board urged that in the course presentations emphasis be placed upon the obligation of all nurses who are to render services under the program to comply with the provisions of the Medical Practice Act and the law governing the practice of nursing, obliging nurses to render services to patients only under the specific direction of a regularly licensed physician or surgeon in each particular case.

Filed (page Tr 133)

Separate Department of Mental Health
(Reference Committee "F")

A conference between the Special Task Force of MSNJ and Commissioner Clifford of the New Jersey Department of Institutions and Agencies was held on May 17, 1972, at the Department's Headquarters in Trenton.

The Special Task Force initiated discussion of MSNJ's position in favor of a separate Department of Mental Health. The Commissioner indicated that basically he was neutral on this issue. He did indicate, however, that no one as yet had presented any creditable evidence in support of a separate Department, nor clearly shown why the purportedly inadequate mental health program in New Jersey cannot be upgraded and administered through the Department of Institutions and Agencies. Commissioner Clifford did state that at the present time the Governor is apparently unalterably opposed to the creation of a separate Department of Mental Health.

Filed (page Tr 133)

Training Center for Drug Abuse Prevention and Treatment
(Reference Committee "F")

The Deputy Director of the Division of Narcotic and Drug Abuse Control of the New Jersey Department of Health requested MSNJ's support of a proposal that would establish, as a pilot project, a Training Center for Drug Abuse Prevention and Treatment that would provide community leaders of various disciplines with a common fund of knowledge that they can bring to bear cooperatively against drug abuse in New Jersey.

The Board recorded itself as approving the establishment of the pilot project.

Filed (page Tr 133)

Alcoholism Detection and Prevention Clinics
(Reference Committee "F")

As directed by the 1972 House of Delegates, New Jersey's Delegation to the AMA introduced a resolution on Alcoholism Detection and Prevention Clinics during the AMA Annual Convention this past June.

Resolution #66 was sent to Reference Committee "E" where it was considered in conjunction with resolution #85 on the subject of

AMA policy statement on alcoholism. On the recommendation of the Reference Committee, the AMA House adopted a substitute version of resolution #66, in lieu of resolution #85, the "Resolveds" of which read:

Resolved, that the House of Delegates of the AMA encourage all constituent societies to work toward the establishment and maintenance of detection and prevention services and the adoption of treatment programs for alcoholism and alcoholism abuse; and be it further

Resolved, that early recognition of alcohol abuse and alcoholism, as well as successful rehabilitation of patients who abuse alcohol, requires services directed to the non-medical components of the disease.

Filed (page Tr 133)

Environmental Health

(Reference Committee "G")

On the recommendation of Reference Committee "G", the 1972 House of Delegates adopted resolution #22, which called upon MSNJ to urge the investigation of methods that are non-polluting and capable of recycling wastes, thereby aiding in the restoration of the atmosphere, water and terrain, as well as lessening the depletion of national resources.

Under date of June 2, 1972, the Secretary of the Board of Trustees forwarded a copy of the resolution to the Commissioner of the New Jersey Department of Environmental Protection with the request that the necessary steps be taken to accomplish the resolution's objectives.

Filed (page Tr 137)

Fitness to Drive

(Reference Committee "G")

Resolution #23 from the 1972 Annual Meeting called upon MSNJ to study the form distributed by the New Jersey Division of Motor Vehicles which contains a question whereby the physician is to supply an opinion as to whether or not a patient is fit to drive.

The matter is being taken up with the New Jersey Division of Motor Vehicles and is being pursued cooperatively.

Filed (page Tr 137)

Sanitary Disposal of Sewage from World Trade Center Buildings in New York City

(Reference Committee "G")

Resolution #29 of the 1972 House of Delegates called upon MSNJ to urge that no certificate of occupancy be granted for the two World Trade Center buildings in lower New York City until the New York Port Authority provides for sanitary disposal of sewage wastes from them.

The following replies have been received in acknowledgment of the resolution:

a. *From Henry I. Fineberg, M.D., Executive Vice-President of the Medical Society of the State of New York* . . . The resolution was presented to the Executive Committee of the Medical Society of the State of New York, at its meeting on June 14. The Executive Committee at that time supported the position of MSNJ.

b. *From Mary C. McLaughlin, M.D., Deputy Health Services Administrator of the City of New York* . . . "In January of this year I was appointed Deputy Administrator in the Health Services Administration and Dr. Joseph A. Cimino assumed the Commissionership. Hence, I am referring your letter to him for his consideration."

c. *From Hayden B. Johnson, Coordinator, Office for Environmental Programs, The Port of New York Authority* . . . "Like all other buildings in Manhattan, the World Trade Center was designed to be, and is, directly connected to the New York City sewer system. For many years, all sewage from Manhattan south of 72nd Street has been released by the City into the Hudson or East Rivers. However, the City of New York has been constructing a new sanitary sewer system and treatment plant which would permit the discontinuance of this practice. At the time the Trade Center was planned, we worked closely with the City of New York and were assured that the sewage system would be in full operation by 1967. The Interstate Sanitation System described the situation in a letter to the Monmouth County Bayshore Outfall Authority:

"'In the 1965 Annual Report of the Interstate Sanitation Commission, it was stated that the Manhattan Interceptor and Pumping Station were under construction which would intercept the raw sewage from the lower portion of Manhattan and that this should be completed by the end of 1967. The pumping station would discharge under the East River to a new treatment plant then under construction in Brooklyn which is now known as the Newton Creek Pollution Control Plant.'

"'Our 1967 Annual Report stated that the Newton Creek Treatment Plant was completed in September 1967 and was receiving wastes from the tributary areas of Brooklyn and Queens. It was further reported that the Manhattan Pumping Station had not been completed, and therefore the flow from Manhattan would not be sent to the plant until 1968. Construction continued to be slowed down on the pumping

station due to foundation problems, and we reported in our 1968 Annual Report that it did not look as if the pumping station would be completed until the last quarter of 1970. However, even at that time, there did not seem to be any doubt that the construction would be completed in ample time to receive any wastes generated by the World Trade Center.'

"We are now informed by the City that the pumping station will be in operation no later than the Spring of 1973. At that time, all of the sewage from the west side of Manhattan and from Lower Manhattan, including that from the Trade Center, will be pumped to the Newtown Creek Pollution Control plant.

"As to the effect of World Trade Center sewage on the water quality of the New Jersey beach areas, the New York City Bureau of Water Pollution Control stated late last year in a letter to a public official of Matawan Township that:

" 'It is difficult to segregate the pollutants reaching Raritan Bay by source, because of complex tidal interchanges and the configuration of the harbor. However, you may be interested to know that the Passaic Valley Sewerage Commission alone contributes about one-third of all B.O.D. reaching the upper harbor. A rough calculation shows that the total pollutant load of the World Trade Center to the upper harbor (north of the Narrows) cannot be more than a small fraction of one percent of the total load. Certainly considerably less than this percentage will reach Raritan Bay, which is influenced far more by the Raritan River and the Arthur Kill.'

"On this basis, it would seem doubtful that by the time the water from the Upper Bay reaches and mixes with the ocean waters off the New Jersey beaches, the World Trade Center effluent would be very significant."

Filed (page Tr 137)



Dr. McGuire accepting Trustees' Plaque from Board Chairman, Dr. Campo

Supplemental Report

As the result of its May 11 meeting, the Board of Trustees directed several items to the attention of the 1973 House of Delegates. The Board therefore submits this supplemental report, which has been compiled since the preparation of its annual report.

New Jersey Health Care Council
(Reference Committee "A")

At its May 11, 1973 meeting, the Board of Trustees approved the establishment of the New Jersey Health Care Council, which consists of the presidents or their designated representatives, alternates, and the executive directors of the various associations representing the providers of health care services. The purpose of the organization is to safeguard and improve the delivery of adequate, needed health care services of quality to the public, in a manner consonant with the optimum efficiency of health profession activities.

Filed (page Tr 126)

Uniform Procedural Terminology Project
(Reference Committee "F")

As is indicated in the Annual Report of the Council on Medical Services, the Board of Trustees approved the implementation of a project designed to study the reporting and payment of claims for services rendered under Medicare and Medicaid by means of improved procedural terminology. Over two-hundred members practicing various specialties were selected on a random computer basis to participate. Personal interviews will be conducted by Prudential professional relations representatives. The Health Services and Mental Health Administration of HEW is also participating. All data collected will be made available to The Medical Society of New Jersey.

Filed (page Tr 133)

MSP Board of Trustees-Nominations
(Reference Committee "C")

Medical-Surgical Plan of New Jersey has submitted the following nominees for terms on the Board of Trustees of Medical Surgical Plan of New Jersey, as indicated:

Three-year term (1973-1976):

Name	*Type of Practice*	*Member of Component Society*
A. Guy Campo, M.D.	General Practitioner	Gloucester County
Edgar P. Eaton, Jr.	Businessman	———
Mortimer J. Fox, Jr.	Businessman	———
Joseph M. Keating, M.D.	Obstetrician	Passaic County
John J. McGuire, M.D.	Surgeon	Essex County
Walter H. Miller, D.O.	Osteopath	———
Henry J. Mineur, M.D.	Internist	Union County
John R. Nevin	College Administrator	———
Ronald K. Seywert	Businessman	———
John F. Waters	Labor Leader	———

Two-year term (1973-1975):

Name	*Type of Practice*	*Member of Component Society*
Mrs. Josephine B. Janifer	Social Worker	———
William Mortenson	Businessman	———

One-year term (1973-1974):

Name	*Type of Practice*	*Member of Component Society*
Mrs. Zelda Paulsen	Businesswoman	———
I. E. Shaffer	Businessman	———

The following persons will continue membership on the Board until the expiration of their terms in the year indicated—or until their successors are elected and qualified:

Terms expiring 1974:

Name	*Type of Practice*	*Member of Component Society*
Edwin H. Albano, M.D.	Pathologist	Essex County
William M. Chase, M.D.	Internist	Essex County
Lloyd M. Felmly	Retired Newspaper Editor	———
John Kelley	Labor Leader	———
Samuel J. Lloyd, M.D.	Medical Consultant	Mercer County
Theron L. Marsh	Banker	———
Rudolph C. Schretzmann, M.D.	Obstetrician	Bergen County
Charles O. Tyler, M.D.	Pediatrician	Camden County

Terms expiring 1975:

Name	*Type of Practice*	*Member of Component Society*
Donald T. Akey, M.D.	Surgeon	Middlesex County
Albert G. Boyd	Hospital Administrator	———
Joseph A. Cox, M.D.	Anesthesiologist	Union County
Charles L. Cunniff, M.D.	Internist	Hudson County
Frederick Hipp, Ph.D.	Executive Vice President, New Jersey Educational Association	———
Warren H. Simmons, Jr.	Businessman	———
Sidney I. Simon, Ph.D.	College Professor	———
Morgan Sweeney	Labor Leader	———
Robert E. Verdon, M.D.	General Practitioner	Bergen County

Approved (page Tr 129)

Judicial Council

John S. Madara, M.D., Chairman, Salem

(Reference Committee "A")

From official records, the Judicial Council here presents a summary of its operations and those of county judicial committees for the period May 8, 1972 through March 25, 1973.

By Judicial Committees

Complaints reported as disposed of 34

Alleging:

Dissatisfaction concerning fees	15
Unprofessional conduct	3
Dissatisfaction concerning medical procedures	2
Over-Utilization of services	2
Unethical conduct	2
Dissatisfaction concerning professional ethics	10

By the Judicial Council

Meetings held	6
Official communications acted upon	31
Appeal hearings requested	6
Appeal hearings granted	1
Formal opinions rendered	0

Of the six requests for appeal hearings one request was sent back to the county judicial committee for a proper hearing; four requests were denied after careful review of the record indicated that the county judicial committee had been presented with all the relevant and material facts necessary to make a determination; one case was heard on appeal, and the decision of the county judicial committee was reaffirmed. In conjunction with this decision, the Judicial Council unanimously voted to recommend that physicians always discuss their charges in advance with patients, whenever possible, and that, where applicable, they display, in their waiting rooms or offices, signs indicating that they participate in the Prevailing Fee Program of the Medical-Surgical Plan of New Jersey or in its Basic Service Coverage.

In the course of the year, the Council offered *obiter dicta* on the following topics:

(1) *Confidentiality of the Patient:* The Judicial Council directed that a physician may not disclose information without the patient's permission, even to another physician, because if he does so, he violates the law. Moreover, as regards the ethicality of such a practice, the Council was in agreement that since the ethical physician is expected to observe all laws, disregard of the confidentiality of the patient in violation of law would carry an overtone of unethical conduct.

(2) *Imposing Upon Third Party Complainants the Obligation to Agree to Accept and Abide by Decisions of the Judicial Mechanism:* The Council agreed that this exaction would be in conflict with the Society's Bylaws and could only be effected by amendment of the relevant sections of the Bylaws.

(3) *Question as to Whether the Word "Institute" in the Title of an Organization of Associated Physicians is in Violation of any New Jersey Statute:* The Council, as the result of research and information made by the Society's Legal Counsel, reported that the use of the word "Institute" in such title is not in violation of pertinent provisions of the Medical Practice Act concerning advertising. The Institute is properly incorporated and operating within the provisions of the Professional Service Corporation Act.

(4) *Announcement of Availability of Trial Cytology Kits from a Cytology Center in Another State:* The Council stated that the materials submitted constituted merely a formal announcement of services available to physicians and was not a solicitation of patients.

(5) *Request for the Establishment of Guidelines Regarding the Sterilization of Women in a Specific Hospital:* The Council found that this inquiry did not fall within the purview of its responsibilities and duties and advised that the matter should be brought to the attention of the legal counsel of the hospital involved or the New Jersey Hospital Association.

(6) *Third Party Complaints:* In the course of the year the Judicial Council has had inquiries from several judicial committees as to the desirability of declaring that no complaint made by a third party will be acceptable for processing under the judicial mechanism unless the patient or patients receiving the medical services involved also join with the third party in the complaint. The Judicial Council has responded to such inquiries by pointing out that a limiting provision of this character would be in conflict with Chapter VII of the Bylaws of The Medical Society of New Jersey and could only be effected by appropriate amendment of those Bylaws. Under the "Duties of the Judicial Council," Chapter VII, Section 4 of the Bylaws, Subsection 4 declares that one duty is "to receive inquiries, complaints, or accusations from any source concerning the professional conduct or ethical deportment of members of this Society for immediate reference to the appropriate county judicial committee." This is the section that would have to be amended if a limiting provision were decided upon. The Judicial Council is of the unanimous opinion that to discourage submission of third party complaints to the judicial mechanism and to stimulate them instead to go to court would be in contravention of one of the basic public relations objectives for which the judicial mechanism was initially established.

Conference With Chairmen of Component Committees

On March 25, the Council held a conference with the chairmen of the judicial committees, executive secretaries, and members of the judicial committees of component societies, at which copies of the newly revised "Rules and Regulations" were distributed and individually discussed. Questions were answered covering all aspects of the judicial mechanism. The purpose of the conference was to achieve a better understanding of, and increased efficiency in, the operation of the Society's statewide judicial mechanism. There were 24 in attendance representing 17 out of 21 counties.

I express my warm thanks to the members of this Council—Doctor Fitch, Doctor Olpp, Doctor Moriconi, and Doctor Durham—for their diligence and the time taken from their practice; to our Legal Counsel, Mr. Mincher; our Stenographer, Mrs. June O'Hare, and a special thanks to our Executive Director, Mr. Richard I. Nevin, for his wisdom in wording our difficult decisions, and for his unfailing guidance over the many years he has been privy to our deliberations.

Filed (page Tr 126)

ACTION TO LIMIT DEBATE

At its first session on Saturday, May 12, 1973, the House of Delegates agreed, upon motion, that no one may speak more than once on any given subject, except by express permission of the House; and that the time be limited to four minutes per speaker, subject to the same exception.

Executive Director

Richard I. Nevin, Trenton

(Reference Committee "A")

It has been a year of intense activity, of painstaking evaluation of, and cautious adaptation to the pressures and changeful influences to which our Society and its members are progressively exposed, and of decisions that must inevitably influence our future activities and status. Evidence of the scope of concern is manifest in proposed changes in Constitution and Bylaws to eliminate the old classification of associate membership and to assign that membership classification instead to interns and residents; in the call for final action by the House of Delegates on the adoption of an added requirement for continuing medical education for maintenance of membership in The Medical Society of New Jersey and its component societies; in the vigorous steps taken to incorporate and activate a foundation for the evaluation of medical services by means of a statewide, efficient mechanism of peer review; and in a stepped-up, expanded program of public relations. We have maintained all our old liaisons with other organizations and agencies and have cultivated new ones. In the interest of fuller understanding and better cooperation, we have striven assiduously to improve our communications with our component societies, the specialty societies, and the American Medical Association. The tempo of our activities has progressively accelerated, and must so continue unremittingly if we are to meet and deal with the diversified challenges of our times.

The reports before the House in this annual meeting summarize the substance of what has been essayed and accomplished. Likewise, they reflect the commendable work of all the agencies of the Society at all levels, from the Board of Trustees and its Executive Committee through all our councils, committees, and individually designated official representatives. Not least, they reflect the loyal and superlatively competent work of the members of our staff. As Executive Director, I have been inspired and honored to be part of all that has been done. It is my hope that the spirit and verve which have made possible as much as has already been achieved will continue and flourish, so that still greater strength, resourcefulness, and unity will characterize our distinguished Society in the days and years that lie ahead.

This is the twenty-third annual report of mine to the House of Delegates. For me it has a poignant uniqueness, since I realize that it will be the last that I shall submit. In May of 1972, I informed the Board of Trustees at its reorganization meeting of my intention to avail myself of my eligibility to retire as of June 1, 1973. Through all the years I have striven to give this beloved Society my vigorous best. I do not feel that I can assuredly continue so to serve, and therefore I beg leave to relinquish the heavy and demanding burdens of the Executive Directorship now, before the standard of my service is diminished or compromised in any way or to any degree that might embarrass The Medical Society of New Jersey or myself.

My years as chief of staff have been splendidly gratifying to me because whereas I expected to find myself laboring with distinguished associates, it has been my happy fortune to find them also good friends. I take my leave of them and you as co-workers, but as long as I live I shall hold you in my heart as good friends.

I have every confidence that you will find in Mr. Maressa an able and loyal Executive Director. It is a matter of pride to me to have brought him to the Society. I have the same affections and high regard for every other member of the staff. Without them the work of the Society could not go on. I am happy to leave you in such good hands. May you all achieve prodigies of honorable accomplishments together!

Filed (page Tr 126)

Annual Meeting

Arthur Bernstein, M.D., Chairman, Maplewood

(Referenee Committee "H")

The Committee met in June to formulate plans for the 207th Annual Meeting in accordance with directives of the 1972 House of Delegates and of the Board of Trustees. It was noted that the 1972 annual reports of the Committee on Annual Meeting, Scientific Exhibits, and Scientific Program were approved, with commendation, by the 1972 House. A second meeting was held in October with Officers of MSNJ's Scientific Sections and representatives of New Jersey specialty societies.

The proposed daily schedule for the 1973 Annual Meeting was submitted to and approved by the Board of Trustees in July. The final meeting of the Board (1972-73) will be held in Haddon Hall at 4 p.m., Friday afternoon, May 11; and the reorganization meeting is scheduled for 8 p.m., Tuesday evening, May 15.

Following the revised schedule of last year, the first session of the House of Delegates will be held at 2 p.m., Saturday, May 12; and the official guests will be called upon to make brief presentations at this session only. Also during the first session, the President of the College of Medicine and Dentistry of New Jersey will be called upon to receive the AMA-ERF checks.

The second (election) session of the House, to be held at 3:30 p.m. on Sunday, will be followed by the farewell message of the President and the inaugural address of the President-Elect. This, in turn, will be followed in the Windsor Room by the 16th Golden Merit Award Ceremony. The reception for GMA recipients and their families will be held in the Derbyshire Room immediately thereafter.

The third session (Part I), will take place on Monday, May 14, to consider the reports of those reference committees that meet on Saturday ("A", "B", "D", "G", and Constitution and Bylaws); Part II of the third session of the House will be held on Tuesday, May 15, at 9 a.m. to consider the reports of those reference committees that meet on Sunday ("C", "E", "F", and "H"). The success of the recommended change in format whereby reference committees meet on two different days was most gratifying, and the 1972 House approved a recommendation of the reference committees that this same format for meetings of the reference committees be followed again this year to allow a fair basis of comparison to be established.

The Nominating Committee will meet at 5 p.m. on Saturday; reference committees are scheduled for 3 p.m. on Saturday and for 10 a.m. on Sunday. Reference committee reports will be made available in advance of distribution to the House to members of the reference committees and to one officially designated representative of each component society.

Official delegates from the Board of Trustees of the American Medical Association, Connecticut State Medical Society, and the Medical Society of the State of New York will attend the 207th Annual Meeting. Invitations have been issued to the Presidents of the Medical Society of Delaware, the Medical and Chirurgical Faculty of Maryland, and the Pennsylvania Medical Society to be the guests of MSNJ. The Presidents of the allied associations (New Jersey State Bar Association, New Jersey Dental Association, New Jersey Hospital Association, New Jersey State Medical Assistants Association, New Jersey State Nurses' Association, New Jersey Association of Osteopathic Physicians and Surgeons, and the New Jersey Pharmaceutical Association) have again been invited to be our guests at the Annual Dinner-Dance on Monday evening.

Registration will open in the Exhibit Hall at 10 a.m., on Saturday; exhibits will be presented from 12 noon on Saturday through 5 p.m. on Monday.

Fifteen outstanding scientific sessions are scheduled for Sunday and Monday mornings and afternoons, during hours which will not conflict with the sessions of the House. Roche Laboratories, Division of Hoffmann-La Roche, Inc., will again sponsor the Motion Picture Theatre. A selection of up-to-date, informative and timely films will be shown on Saturday, Sunday, and Monday.

In an effort to provide relaxation and entertainment for delegates, members, guests and their wives, and members of the Woman's Auxiliary, there will be a Reception, Buffet-Dinner, and Dance on Saturday evening. Tickets will be on sale at the registration desk; and, as in the past, technical exhibitors will be the guests of the Society.

The Inaugural Reception honoring President-Elect and Mrs. Boylan will be held on Sunday evening. All registered members, official guests, and their wives are cordially invited to attend; admission will be by badge. The Annual Dinner-Dance honoring President and Mrs. D'Elia, has been scheduled for Monday evening. Tickets will be on sale at the Registration Desk.

The Alumni Association of the Jefferson Medical College will sponsor a Reception on Monday evening, preceding the Annual Dinner-Dance.

The Society for the Relief of Widows and Orphans of Medical Men of New Jersey will hold its annual meeting on Sunday afternoon during the 207th Annual Meeting of MSNJ.

The advance program, prepared under the auspices of the Committee on Annual Meeting, was mailed early in February to the membership, invited speakers and guests, non-member exhibitors, and editors of journals of nearby state medical societies. The April (Convention) issue of *The Journal* will carry the detailed day-by-day outline of the annual meeting, as well as abstracts of scientific session presentations. For the first time since 1959, the *Official Program,* which is distributed to all who register at the convention, will also carry abstracts of the Scientific Session presentations.

The Committee is grateful to the Prudential Insurance Company of America for its continued cooperation in sponsoring the Coffee Lounge; and to the American Association of Medical Assistants, State of New Jersey, for again staffing the Message Center. This year, we will feature 40 technical exhibits, 15 scientific exhibits, and 16 informational exhibits. All exhibits, the Coffee Lounge and the Message Center will be housed in the Exhibit Hall, Lobby floor, Haddon Hall. Everyone in attendance at the Annual Meeting is strongly urged to visit the exhibits; admission to the Exhibit Hall will be by badge only.

The Cost Analysis of the 206th Annual Meeting contained a recommendation of the Committee on Finance and Budget, which was approved by the 1972 House of Delegates, that the 1973 assessment include $2.50 per capita assessment designated for each member's Annual Meeting registration fee.

In discussion of possible ways and means of reducing the Annual Meeting deficit, it was pointed out that most organizations charge a registration fee which places the financial burden only on those attending the meeting. The Committee firmly believes that all members of MSNJ should financially support the Annual Meetings and recommended that the 1974 assessment include an assessment of $5.00 per capita designated as each member's Annual Meeting registration fee. This recommendation was approved by the Board and referred to the Committee on Finance and Budget.

In a further effort to curtail expenses, the Committee was charged with the responsibility of limiting, wherever possible, the number of complimentary tickets issued for the Saturday evening Reception and for the Annual Dinner-Dance.

In accordance with a directive of the Board, invitations to contribute to the Educational Fund of MSNJ, in lieu of exhibiting, were sent out in early February. We are grateful to

the following for their generous contributions: Geigy Pharmaceuticals, Johnson and Johnson, Knoll Pharmaceutical, Mead Johnson Laboratories, Reed and Carnrick, A. H. Robins Company, Upjohn Company, and Winthrop Laboratories.

The House of Delegates has already approved the following annual meeting dates, which have been confirmed with Haddon Hall:

208th Annual Meeting—
Saturday-Tuesday, 11-14 May 1974
209th Annual Meeting—
Saturday-Tuesday, 10-13 May 1975
210th Annual Meeting—
Saturday-Tuesday, 8-11 May 1976

Recommendation

That the 211th Annual Meeting of The Medical Society of New Jersey be held in Haddon Hall, Atlantic City, Saturday-Tuesday, 7-10 May 1977.

Approved (page Tr 138)

Filed with notation and commendation to the chairman (page Tr 138)

Scientific Exhibits

John J. Thompson, M.D., Chairman, Caldwell

In lieu of scheduling a meeting, the Committee was polled by mail in early November and requested to review the application for space, the regulations governing Scientific and Informational Exhibits, and the listing of invitations to exhibit. No changes were made by the Committee on the existing application and regulations, and it was agreed that applications for space in the 1973 Scientific Exhibits should be mailed early in November to the following:

1. Medical Directors of Philadelphia, New Jersey, and New York City hospitals;

2. Deans of Philadelphia, New Jersey, and New York City Medical Schools;

3. 1973 Scientific Section Speakers;

4. New Jersey State Departments of Health and of Institutions and Agencies;

5. MSNJ Committee Chairmen.

Letters were directed to editors of journals of nearby states requesting that they carry items in their publications calling attention to our meeting, and inviting interested members of their societies to submit applications for space in the Scientific Exhibits. Presidents of component societies were requested to again cooperate in stimulating interest on the part of their members and their area hospitals in presenting Scientific Exhibits that would be of interest to the over-all membership of MSNJ.

The *Membership Newsletter* carried items calling attention to and urging participation in the Scientific Exhibits; and *The Journal* included copy of the application and regulations governing Scientific Exhibits in the November and December issues.

The Committee met formally in January, reviewed all applications on hand and assigned booth space. As of this writing, there will be 16 Scientific Exhibits and 16 Informational Exhibits. Descriptive write-ups of all Scientific and Informational Exhibits will appear in the April (Convention) issue of *The Journal.*

In accordance with previous policy, the Committee agreed to a minimum charge of $150 per ten feet of space occupied by Informational Exhibits—with the exception of those presented by Committees of MSNJ, the Society for the Relief of Widows and Orphans of Medical Men of New Jersey, the Academy of Medicine of New Jersey, the Essex County Water Pollution Committee, and JEMPAC. The charge for space in the Informational Exhibits exceeding ten feet will be based upon a rate of $15 per front foot.

The Committee on Awards will meet in the Convention Office, Haddon Hall, to discuss and agree upon the proposed recipients prior to the presentation of awards. The award plaques and certificates will be presented on the following basis: first and second place award plaques to New Jersey exhibitors; first and second place award plaques to out-of-state exhibitors; a special award plaque from the Committee on Scientific Exhibits to a New Jersey exhibitor; certificates of merit to students from each of New Jersey's two medical schools; and honorable mention certificates to

New Jersey and out-of-state exhibitors (number of certificates to be determined on the basis of merit.

Last year the award presentations were made on Sunday and announcement of the winners was made at the second session of the House of Delegates. It was noted that last year immediately following the presentation of plaques and certificates on Sunday the majority of the winners left and were not in attendance at their booths for the remainder of the open exhibit hours (until 5:00 p.m. on Monday).

This year, in an effort to forestall the early departure of Award recipients, the Award plaques and certificates will be presented on Monday afternoon; and announcement of the winners will be made at the third session (Part I) of the House.

Filed with notation (page Tr 139)

Scientific Program

Arthur Bernstein, M.D., Chairman, Maplewood

The Officers of the 1973 Scientific Sections met in October with the Committee on Annual Meeting, together with representatives of the New Jersey specialty societies. Your Committee is pleased with the steadily improving rapport and excellent cooperation between MSNJ and the New Jersey specialty societies.

The Chairman of MSNJ's Section on Rheumatism requested the formation of a new MSNJ Scientific Section on Physical Medicine and Rehabilitation in an effort to establish a closer relationship between our Society and the specialty society (New Jersey Society for Physical Medicine and Rehabilitation). The Board of Trustees approved a recommendation that this new section be established within the framework of MSNJ's Scientific Sections, and that a Chairman and a Secretary be elected to serve beginning with the 1974 Annual Meeting.

Your Committee is gratified by the overwhelming success of the scientific programs since the initiation of co-sponsorship by New Jersey specialty societies several years ago. All of MSNJ's Scientific Sections will meet in 1973, and all of the fifteen sessions to be presented will be co-sponsored by one or more of the New Jersey specialty societies. The following schedule has been set up for the 1973 Scientific Sessions:

Sunday, 13 May 1973—a.m.

Joint Session on Allergy, Dermatology—co-sponsored by New Jersey Allergy Society
Session on Cardiovascular Diseases—co-sponsored by New Jersey Chapter, American College of Cardiology
Session on Ophthalmology—co-sponsored by New Jersey Academy of Ophthalmology and Otolaryngology

Sunday, 13 May 1973—p.m.

Session on Anesthesiology—co-sponsored by New Jersey State Society of Anesthesiologists.
Session on Neurosurgery and Neurology—co-sponsored by New Jersey Neurosurgical Society
Session on Psychiatry—co-sponsored by New Jersey Psychiatric Association and New Jersey Psychoanalytic Society

Monday, 14 May 1973—a.m.

Joint Session on Chest Diseases, General Practice, Medicine—co-sponsored by New Jersey Chapter, American College of Chest Physicians, New Jersey Chapter, American Academy of Family Physicians, and New Jersey Society of Internal Medicine
Session on Clinical Pathology—co-sponsored by New Jersey Society of Pathologists
Joint Session on Obstetrics and Gynecology, Pediatrics—co-sponsored by New Jersey Chapter, American Academy of Pediatrics
Session on Orthopedic Surgery—co-sponsored by New Jersey Orthopaedic Society and New Jersey Chapter, American College of Emergency Physicians
Session on Rheumatism—co-sponsored by New Jersey Society of Physical Medicine and Rehabilitation
Session on Surgery—co-sponsored by New Jersey Chapter, American College of Surgeons

Monday, 14 May 1973—p.m.

Joint Session on Gastroenterology and Proctology, General Practice, Medicine—co-sponsored by New Jersey Gastroenterological Society, New Jersey Chapter, American Academy of Family Physicians, and New Jersey Society of Internal Medicine
Joint Session on Obstetrics and Gynecology, Radiology, Urology—co-sponsored by New Jersey Chapter, American College of Radiology
Joint Session on Otolaryngology, Plastic and Reconstructive Surgery—co-sponsored by New Jersey Academy of Ophthalmology and Otolaryngology and New Jersey Society of Plastic and Reconstructive Surgeons

The Committee is pleased to announce that approval has been granted by the American Academy of General Practice for two prescribed hours for attendance at the Joint Session on Chest Diseases, General Practice,

and Medicine, to be presented on Monday morning; and for two prescribed hours for attendance at the Joint Session on Gastroenterology and Proctology, General Practice, and Medicine, to be presented on Monday afternoon, 14 May.

The following luncheons have been scheduled in conjunction with the 1973 Scientific Sessions:

New Jersey State Society of Anesthesiologists, Inc.
New Jersey Chapter, American College of Chest Physicians (annual Selman A. Waksman Lecture)
New Jersey Chapter, American College of Emergency Physicians
New Jersey Academy of Ophthalmology and Otolaryngology
New Jersey Orthopaedic Society
New Jersey Society of Pathologists
New Jersey Chapter, American Academy of Pediatrics

In addition, the New Jersey Committee on Trauma, American College of Surgeons, has scheduled its Annual Trauma Oration and luncheon on Saturday; and the New Jersey Medical Women's Association, Inc. will hold a Brunch-Meeting on Sunday.

A total of 51 outstanding member and guest speakers will participate in the 1973 Scientific Sessions.

In the past MSNJ has, in lieu of honoraria, provided guest (non-member) speakers with complimentary overnight accommodations at Chalfonte-Haddon Hall; meals and gratuities during overnight stay at hotel; and travel expenses to and from home city-Atlantic City. Any honoraria presented in the past have been the sole responsibility of the specialty societies.

Several representatives of the specialty societies pointed out that, in addition to lending their names as co-sponsors of MSNJ's Scientific Sessions, they also have assumed responsibility for setting up the programs and engaging the speakers. This does not necessarily mean that MSNJ's Scientific Section Officers are not performing their duties, but merely that our Section Officers are members or officers of the New Jersey specialty societies as well. Therefore, it was recommended—and approved by the Board of Trustees 11/19/72—that, beginning in 1973, MSNJ pay honoraria up to $100 per guest speaker, in addition to the already established payment for hotel accommodations, meals, gratuities, and travel expenses. In consideration of the foregoing, it was pointed out that the Board of Trustees has, for the past several years, directed that, in lieu of presenting exhibits, pharmaceutical houses, book publishers, etc., be invited to contribute to the Education Fund of MSNJ. In 1972, solicitation of funds resulted in contributions amounting to $1,300 from eight companies. Acknowledgement of these contributions was carried in the advance program, the April (Convention) issue of *The Journal,* and in the *Official Program,* and the money was earmarked for use in offsetting expenses incurred in presenting the Scientific Sessions.

The Policies Governing Scientific Sessions were revised as follows to incorporate the new ruling concerning honoraria and reimbursement to guest-speakers:

The Society is deeply grateful to its speakers and will pay honoraria up to $100 per guest-speaker, in addition to providing complimentary overnight accommodations at Chalfonte-Haddon Hall, meals and gratuities during overnight stay at hotel, and travel to and from home city-Atlantic City—estimated not to exceed $100 per guest-speaker. These honoraria are for guest-speakers only. It is suggested, but not mandated, that there be no more than two such invited speakers per scientific session. The travel allowance should be sufficient for guest-speakers from nearby states, which should cover the majority. In the case of those from the middle-west, or other distant points, traveling expenses would be more. However, the Committee on Annual Meeting will deal with these individually as they come up, and adjust its budget accordingly. It is well to have a definite allowance established.

Filed with notation (page Tr 139)

Credentials

Louis F. Albright, M.D., Chairman, Spring Lake

(Reference Committee "A")

The Committee on Credentials, throughout the year, reviewed and acted upon membership applications and their supporting credentials as submitted through the component societies.

The Committee extends appreciation to the secretaries of component societies, and to those who assist them, for their cooperation in processing membership applications. It would be especially helpful to the Credentials Committee of MSNJ if those who process credentials in the component societies would call specific attention to any deficiencies or questionable data being submitted on the application form. This procedure will help insure more accurate and speedy evaluation of credentials.

The following statistical breakdown reflects the Committee's activities during the period March 1, 1972 to February 28, 1973.

	Associate	*Active by Advancement*	*Active*	*Total*
Received	407	341	90	838
Reviewed and found:				
Satisfactory	367	303	70	740
Unsatisfactory	0	0	0	0
Pending	40	38	20	98
Total	407	341	90	838

Filed (page Tr 126)

1972 TRANSACTIONS

At its first session on Saturday, May 12, 1973, the House of Delegates approved the Transactions of the 1972 House of Delegates as published in the July 1972 issue of THE JOURNAL and distributed to the membership.

Honorary Membership

Ralph M. L. Buchanan, M.D., Chairman, Phillipsburg

(Reference Committee "H")

No nominations were submitted this year to the Committee. Consequently, no meetings were held during this administrative year.

Filed (page Tr 139)

Finance and Budget

Nicholas E. Marchione, M.D., Chairman, Vineland
(Reference Committee "B")

A review of the expenses of the first ten months of the current administrative (fiscal) year and an estimation of the expenses for the final two months indicate that the individual budget accounts are sound.

The Journal and Annual Meeting Expense

The (net) *Journal* Deficit is anticipated to be higher than expected, even though this will be the first year that $3.50 of the 1973 per capita assessment designated for each member's *Journal* subscription rate will be applied. The increase in net deficit can be attributed to several factors: (1) reduced volume of national advertising supplied by SMJAB, due in part to the strict disclosure demands of FDA and the failure of pharmaceutical manufacturers to increase advertising budgets despite rising costs and the appearance of new medical publications on the market, while local advertising income has remained relatively stable; (2) the effects of the new rate structure reflecting 15 per cent increase for full and for one-half page advertisements, although effective last year, did not achieve full impact on the *Journal* income until January 1, 1973 when all contracts were renewed; (3) and the effect of a 6.5 per cent production cost increase effective March 1, 1973, as well as the 9.3 per cent increase in 1972. However, the trend set for 1973 is consistent within the printing industry, and it is felt that the printer has rendered another satisfactory year in printing *The Journal.*

For the second year, your Committee recommended, with the concurrence of the Board of Trustees, that the 1974 assessment include a $3.50 and $2.50 per capita assessment designated for each member's *Journal* subscription rate and annual meeting registration rate, that the full amounts realized as of May 31 be applied in 1974 as well as in 1973, and that the Committee on Finance and Budget be called upon to review these allocations annually.

Your Committee was cognizant of the fact that the above action will not completely discharge the deficits incurred each year in these two accounts. Nevertheless, the net deficit in each account will be far less and will readily be charged to the unexpended balance of the fiscal budget.

Medical Education and The New Jersey Academy of Medicine

Your Committee has approved, with the concurrence of the Board of Trustees, the inclusion of $20,000 in the budget of the Committee on Medical Education for 1973-1974 for the Academy of Medicine of New Jersey for postgraduate educational programs and activities, with the proviso that the Committee on Medical Education, with the concurrence of the Board of Trustees, be empowered to expend up to this amount in the course of the administrative (fiscal) year on the basis of need reflected in the 1973-1974 fiscal report to be submitted by the Academy of Medicine to the Committee on Finance and Budget.

Affiliate and Associate Member

Your Committee recommended, with the concurrence of the Board of Trustees, that an assessment be set at $20 per capita for the affiliate and associate member.

New Jersey Foundation for Health Care Evaluation

Your Committee has approved, with the concurrence of the Board of Trustees, the proposed 1973-1974 budget prepared by the Finance Committee of the New Jersey Foundation for Health Care Evaluation. The budget totals $74,160.

1974 Assessment

The computation of unappropriated cash surplus at the close of the current fiscal year is estimated at $194,066.23—29.4 per cent above the $150,000 sum which has been adopted as the desired minimal surplus.

In accordance with Chapter X of the Bylaws, the dues year is January 1 to December 31, and the fiscal year is June 1 to May 31. The Administrative year including the budget, which controls expenditures, is based on the fiscal year. It, therefore, becomes necessary to apportion the 1973 and 1974 per capita assessment to the 1973-1974 fiscal year on the basis of 7/12 of the 1973 assessment for the new fiscal year soon to commence (June 1, 1973) and 5/12 of the 1974 assessment for the latter part of that fiscal year starting January 1, 1974.

The following is the Computation of Cash Surplus and the Determination of the 1974 Assessment:

Proposed budget for 1973-74	$558,989.00
7/12 of 1973 assessment applicable to 1973-74 budget	262,043.00
Amount to be raised by 5/12 of 1974 assessment	$296,946.00
$100.67 × 7,080 members paid = $712,743.60 ×5/12	$296,976.50
Amount to be raised with surplus over $150,000 applied to budget excess at 5/31/73, estimated	$ 44,066.23
Amount needed to reduce the per capita assessment from $100.67 to $90	$ 23,112.67
Remainder of surplus in excess of $150,000	$ 20,953.56
Add the required surplus	$150,000.00
Estimated adjusted cash surplus as of 5/31/73	$170,953.56
$90.00 × 7,080 members paid = $637,200 × 5/12	$273,833.33
plus the amount raised from surplus	$ 23,112.67
Amount to be raised to meet 5/12 requirement	$296,946.00

For each $1,000 increase in the proposed budget add 34¢ to assessment.

For each $1,000 decrease in the proposed budget subtract 34¢ from assessment.

1973-74 Budget

The proposed budget for 1973-1974 totals $558,989. It is the opinion of the Committee that the budget should adequately provide the necessary funds for the efficient operation of the Society's business during the coming year. It is not to be assumed that all sums budgeted will necessarily be utilized.

As requested by the House of Delegates, your Committee is listing explanatory footnotes on accounts which show a marked difference between current and proposed budgets.

Your Committee has included as attachment #1 the basis for the increase in the annual per capita budgetary assessment and also as attachment #2, the 1973 dues assessment for the fifty state societies.

Recommendations

1) That the budget for 1973-74 be adopted in the total sum of $558,989.00.

Approved (page Tr 128)

2) That the 1974 assessment be adopted at $90.00 per capita, with no provision for a contribution to AMA-ERF. The dues assessment will cover a budget allocation, for the fifth consecutive year, to the Academy of Medicine of New Jersey which eliminates the need for a special assessment therefor. Of the $90.00 per capita assessment, $3.50 and $2.50 be designated respectively for the member's *Journal* subscription and Annual Meeting registration; and that the full amounts realized as of May 31, be applied in 1974 as well as in 1973.

Approved (page Tr 123)

3.) That a special assessment be adopted at $10.00 per capita, to serve as a one-time grant to the New Jersey Foundation for Health Care Evaluation; that this special per capita assessment be set in addition to, and not as

part of, the budgetary assessment; and that both be paid at the same time.

Approved (page Tr 128)

4) That an assessment be set at $20.00 per capita for affiliate and associate members.

Approved (page Tr 128)

ACCOUNT	CURRENT 1972-73 BUDGET	FOOT-NOTES	PROPOSED 1973-74 BUDGET
A— 1—Executive Salaries	$ 82,132.00	(1)	$ 74,523.00
A— 2—General Staff Salaries	135,759.81	(1)	166,301.59
A— 3—General Executive Office Expenses	21,000.00	(2)	22,500.00
A— 4—Executive Travel	3,950.00	(3)	6,900.00
A— 5—House Maintenance	25,600.00	(4)	31,100.00
A— 6—Treasurer	7,600.00	(5)	8,000.00
A— 7—Finance and Budget	75.00		75.00
A— 8—Secretary	400.00		400.00
A— 9—Salary Taxes	12,766.19	(6)	17,089.41
A—10—Insurance	11,055.00	(7)	12,300.00
A—11—House Reserve	15,600.00		12,200.00
A—12—MSNJ Pension Plan	1,600.00		1,700.00
A—13—MSNJ Building Loan	14,000.00		13,500.00
C— 2—Legislation	8,400.00	(8)	9,200.00
C— 3—Public Health	2,700.00		2,700.00
C— 4—Public Relations	9,400.00	(9)	46,000.00
C— 5—Medical Services	700.00		700.00
C— 6—Mental Health	1,600.00		1,600.00
D— 1—President-Presidential Offices	15,750.00		15,600.00
D— 2—AMA Delegates	16,600.00		15,000.00
D— 3—Woman's Auxiliary	6,650.00		5,600.00
D— 4—Medical Education	35,800.00	(10)	35,300.00
D— 5—Conference Groups	500.00		500.00
D— 6—Membership Directory	17,000.00		16,000.00
D— 7—Emergency Medical Care	300.00		300.00
D— 8—Credentials	900.00		1,000.00
D— 9—Archives and History	100.00		100.00
D—10—Project Hope-Vietnam	6,000.00		6,000.00
D—11—Medical Defense and Insurance	500.00		500.00
D—12—Membership Inquiry and Complaint	————	(11)	1,000.00
E— 1—Board of Trustees	7,000.00	(12)	7,500.00
E— 2—Contingent	10,000.00		10,000.00
E— 3—Judicial Council	500.00		500.00
E— 4—Legal	7,300.00		7,300.00
E— 6—Medical Student Loan Fund	6,000.00		6,000.00
E— 7—Authorized Reimbursement for Representatives to Meetings	3,500.00	(12)	4,000.00
TOTALS	$488,738.00		$558,989.00

Footnotes for Budget

(1) Increased due to increments granted to both executive and general personnel. The proposed budget provides for two new executive assistants to the Executive Director.

(2) Increased to cover higher luncheon cost and preventive maintenance agreements charged to this account.

(3) Increased to cover the purchase of a new executive automobile.

(4) Increased to cover higher expenses anticipated on Property Tax, Utilities, and Insurance.

(5) Increased to cover higher expenses anticipated in bookkeeping and accounting services.

(6) Increased to cover higher salary taxes resulting from increased staff salaries and employment of additioal personnel.

(7) Increased to cover the additional personnel under the insurance programs provided for the staff of The Medical Society of New Jersey.

(8) Increased due to increment granted to the Legislative analyst as approved by the Board of Trustees, March 18, 1973.

(9) Increased to cover the planned activities in Public Relations in accordance with the action of the House of Delegates at the Special Session, December, 1972.

(10) The Medical Education Committee, with the concurrence of the Board of Trustees, is empowered to expend up to $20,000 in the course of the administrative year (1973-74) to the Academy of Medicine of New Jersey for postgraduate educational programs and activities, on the basis of need reflected in the fiscal report to be submitted by the Academy to the Committee on Finance and Budget.

(11) Account established in compliance with the resolution passed by the Special Session of the House of Delegates, December, 1972.

(12) Increased to cover higher anticipated expenses.

Filed with notation (page Tr 128)

Attachment #1

Basis for the Increase in the Annual Per Capita Budgetary Assessment

In accordance with Chapter X of the Bylaws, the dues year is January 1 to December 31, and the fiscal year is June 1 to May 31. The administrative year including the budget, which controls expenditures, is based on the fiscal year. It, therefore, becomes necessary to apportion the 1973 and 1974 per capita assessment to the 1973-74 fiscal year on the basis of 7/12 of the 1973 assessment ($70 per capita) for the new fiscal year soon to commence (June 1, 1973) and 5/12 of the 1974 assessment ($90 proposed per capita) for the latter part of the fiscal year starting January 1, 1974.

In computing the 1974 per capita assessment, only 5/12 of the needed $100.67 is applicable to the 1973-74 fiscal budget. Thus, only $41.95 or $.42 (rounded) per $1,000.00 increase is applicable.

However, it is possible to reduce the needed 1974 per capita assessment by borrowing from the excess over the desired minimum cash surplus of $150,000.00. The excess is estimated to be $44,066.23 as of May 31, 1973. Therefore, by borrowing 5/12 or $23,112.67 or $10.67 per capita, the 1974 per capita dues assessment may be set at $90.00.

The following includes only those accounts with appreciable increases. The needed assessment for 1974 is determined to be $100.67 or $30.67 higher than the 1973 per capita assessment of $70.00.

Account Code	Description	Explanation for Increase	Budget Increase	Impact on the 1947 Per Capita Assessment $.42 per $1,000 increase
A-1, A-2 and A-9	Executive General Staff Salaries, and Salary Taxes	Increments approved by Action of Board of Trustees 3/18/73	$27,256.00	$11.45
A-4	Executive Travel	New Executive Car	$ 2,950.00	$ 1.24
A-5	House Maintenance	Increased Property Tax on expanded Executive Headquarters	$ 5,500.00	$ 2.31
C-4	Public Relations	Employment of Executive Assistants and expanded Public Relations activities	$36,600.00	$15.37
D-12	Membership Inquiry and Complaint Mechanism	Mandate, House of Delegates 12/10/72	$ 1,000.00	$ .42
		Total	$73,306.00	$30.79

Attachment #2

State Societies Dues for the Year 1973

Below are the fifty State Societies in the order from the highest dues assessment down to the lowest:

1.	Alaska	$200.00	26.	New Mexico	$105.00
2.	Idaho	150.00	27.	New York	100.00
3.	North Dakota	150.00	28.	Georgia	100.00
4.	Iowa	150.00	29.	Kansas	100.00
5.	Nevada	150.00	30.	Maryland	100.00
6.	Dist.of Columbia	145.00	31.	Mississippi	100.00
7.	Wisconsin	145.00	32.	Nebraska	100.00
8.	Delaware	140.00	33.	Oklahoma	100.00
9.	Michigan	135.00	34.	Pennsylvania	100.00
10.	California	135.00	35.	Rhode Island	100.00
11.	Colorado	130.00	36.	West Virginia	100.00
12.	Illinois	130.00	37.	North Carolina	* 95.00
13.	Kentucky	130.00	38.	New Hampshire	95.00
14.	Washington	127.00	39.	Louisiana	85.00
15.	Minnesota	125.00	40.	Massachusetts	85.00
16.	Maine	125.00	41.	Tennessee	80.00
17.	Alabama	125.00	42.	Vermont	80.00
18.	South Dakota	125.00	43.	Florida	75.00
19.	Wyoming	125.00	44.	Missouri	75.00
20.	Arizona	120.00	45.	South Carolina	75.00
21.	Montana	120.00	46.	Connecticut	70.00
22.	Oregon	115.00	**47.**	**New Jersey**	**70.00**
23.	Utah	115.00	48.	Texas	70.00
24.	Indiana	110.00	49.	Ohio	65.00
25.	Arkansas	110.00	50.	Virginia	60.00

*Plus a $50.00 special assessment for five years on a building.



1972-1973 Board of Trustees

Medical Defense and Insurance

Paul J. Kreutz, M.D., Chairman, Elizabeth

(Referenee Committee "C")

In 1972, we had many important additions and expansions to our insurance program which the Society endorses for the benefit of its members. Two new programs were added and three existing programs were expanded. The two new programs were the EPIC Automobile Insurance Program providing low cost automobile insurance for members and their employees and the new Professional Overhead Expense Plan which has very high limits and attractive rates especially for the younger members.

Our Life Insurance Program was increased $100,000 so it now provides a maximum of $250,000 of coverage. Our Hospital Money Program was expanded to $50 and $60 a day. Our Accident and Health Program was expanded so that now the entire program of $2200 a month can be under the Long Term Plan providing accident benefits for life and sickness coverage to age 65.

Details of all the plans including the new and improved ones follow:

Accident and Health Insurance

The Society's accident and health insurance program administered by E. & W. Blanksteen Agency, Inc., has just completed its 43rd year of service to our members. This comprehensive disability income program affords a monthly benefit of up to $2200 during total disability due to injury or sickness. The program consists of two parts: The Basic-Extended Plan and the Long Term Plan. The plans differ primarily in the length of time benefits are payable. For an accident disability, the Basic Plan pays up to five years; the Basic-Extended Plan up to lifetime; and the Long Term plan up to lifetime. For a sickness disability, the Basic Plan pays up to two years; the Basic-Extended Plan up to seven years; and the Long Term Plan up to age 65. Both the Basic-Extended Plan and the Long Term Plan are underwritten by the Nationwide Mutual Insurance Company.

Basic-Extended Plan

The Basic disability plan provides as much as $1200 monthly benefit with the Nationwide Mutual Insurance Company. Benefits are payable from the first day of accident total disability for as long as five years and the eighth day of sickness total disability for as long as two years. Waiting periods of 30 or 60 days are available to provide reduced premiums for those whose circumstances make desirable a plan whose benefits could begin on a later date than 1st day accident and 8th day sickness. The plan also pays, at half the monthly benefit rate, from the first day of accident, partial disability for as long as six months. The plan also includes accidental death and dismemberment benefits. By adding the Extended plan, accident total disability benefits may be extended to lifetime, and sickness total disability benefits may be extended for an additional five years, or a total of seven years altogether.

There are 7,894 Basic policies covering our members with some members having two basic policies.

Long Term-Professional Income Protection Plan

Last year, this plan, through the Nationwide Mutual Insurance Company, was expanded so that all of the members' Accident & Health insurance under the Society's plan can be in the Long Term Plan. In effect, members may take out $1200 of Long-Term insurance in lieu of the $1200 Basic Extended Plan. Benefits are payable for lifetime for accident total disability and to age 65 for sickness total disability. One of the chief purposes of this plan is to provide both accident and sickness disability benefits to the age where other financial arrangements begin to fall into place; such as

annuities, life insurance settlement options, and social security. The plan also affords six months of partial disability at half the monthly benefit rate. Benefits may begin from the 15th, 31st, 61st, or 91st day of disability, with appropriate reductions in premiums. Currently 1,180 members participate in this program which began in 1965.

It is possible for a member to have the various disability plans in almost any combination of monthly benefit and plan to fit personal requirements. The ideal goal for most doctors is to insure about two-thirds of monthly gross income. More monthly benefit than this is unnecessary inasmuch as all benefits are tax free for Federal Income Tax purposes. Members who apply for the Basic-Extended Plan within their new member periods are issued coverage, within certain limits, without regard to medical history.

All of our accident and health policies have the guaranteed Conversion Provision Rider. Briefly, this rider provides that if Nationwide were unilaterally to terminate any of its accident and health insurance programs for members of the Society, the Company is committed to issue a guaranteed renewable policy for the same benefits as those provided each insured member under the Society's program.

Major Expense Plan

Our Major Expense Plan was revised and improved last year and now provides the maximum benefit for each accident or sickness of $25,000 with claimants of Medicare age covered up to $7500 in addition to Medicare benefits. The room and board rate is $100 for intensive care and $50 for all other accommodations. The private duty nursing benefit now takes into account $24 for each 8-hour shift in the hospital. On a three shift day, a maximum of $72 can be paid for nursing coverage.

The deductible amount is $750 for each benefit period. There is *no* coordination of benefits provision for those below Medicare age.

The program now covers 2,686 members, with many members including coverage for their wives and children. New members to the Society may obtain coverage under the Major Expense Plan without regard to medical history provided they apply within their alloted two month new member period. E. & W. Blanksteen Agency, Inc. administers this plan.

Hospital-Money Plan

Our Hospital-Money Policy, administered by E. & W. Blanksteen Agency, Inc., has been improved this year so that it now provides $20, $30, $40, $50, or $60 a day for each day of hospital confinement up to a maximum of 365 days for any one confinement. The $50 and $60 plus were added last year. It can cover member, spouse, and dependent children. New members are able to obtain this program non-selectively as part of their new member privilege. Three hundred fifty-two members participate in this program.

EPIC Automobile Insurance Program

The Society adopted the EPIC Automobile Insurance Program of the Automobile Insurance Company of Hartford, administered by E. & W. Blanksteen, as a solution to the problem many members had of having high automobile insurance premiums and the inability of some of our members to obtain adequate coverage at any price. We are the first medical society in the country to offer this low-cost, guaranteed issue automobile insurance Plan to its members and their employees. The EPIC Plan has the following characteristics:

Four out of five applicants will save 5 to 15 per cent or even more of their present insurance cost.

One out of five *may* pay more (because of driving record, etc.) but will get full coverage.

Five out of five members who hold a valid driver's license and participate in the Authorized Check Plan will be guaranteed a policy that they will have the sole option of accepting.

The key part of the program is the direct servicing of claims by company claim offices and the convenient Authorized Check Plan whereby premiums are automatically deduct-

ed monthly (without extra charge) from your checking account. Up to $1,000,000 bodily injury and property damage coverage is available with all the other important coverage available at your option. No-Fault reductions and special No-Fault coverage are, of course, provided under the Plan.

Some of the savings members have received under the Plan are impressive and we would certainly urge members to obtain a no-obligation quotation from our Administrator to see whether or not they are one of the ones who can participate in the large savings available.

Overhead Expense Program

Many of our members find that their overhead expenses have become quite high what with employees' salaries, rentals, and other fixed expenses pertaining to their practice of medicine. Overhead Expense coverage has now become necessary in the Society-sponsored Program and they have sponsored an excellent program through the National Casualty Company, administered by E. & W. Blanksteen Agency, Inc., that provides up to $2500 monthly benefit beginning with the 31st day of total disability and lasting as long as two full years. This program will be offered in a special non-selective enrollment and if, during this enrollment period, 1500 of our members under the age of 60 apply, all members under age 60 who apply during the enrollment period will be guaranteed issuance of at least $500 monthly benefit provided only that they are members of the Society in the full-time active practice of medicine and are under age 60 at the time the policy is issued. In accordance with IRS regulations, the premiums under this program are considered a business expense and are tax deductible.

Life Insurance—Nationwide Life Insurance Company and Bankers Life Company of Des Moines, Iowa

The maximum coverage under our Life Plan was increased to $250,000 by the addition of the $100,000 maximum coverage Bankers Life Plan in addition to the $150,000 program of the Nationwide Life Insurance Company that has been in effect for many years. During the month of May members will receive information concerning this new and additional program which should make available more insurance at lower cost to our members.

Our original Nationwide Life Insurance Program includes not only the member but also his spouse and dependent children (between the ages of 15 and 21, or up to age 26 if a college student), and employees. An important feature of this expansion is that each person will have his own Five Year Renewable and Convertible Term Policy and it is not necessary for the member to take out insurance for himself in order to provide coverage for a member of his family or an employee. This added feature enables the life insurance program to serve many more needs of our members especially those who wish to provide benefit programs for their employees. The administrators are E. & W. Blanksteen Agency, Inc.

The life program provides each insured person with a Five Year Renewable and Convertible Term Policy with a guaranteed conversion on a non-medical basis to permanent life insurance at any time. The program now provides up to $150,000 of coverage for members and up to $50,000 of coverage for spouse, dependent children and employees.

All coverage is issued in the form of convenient units of $10,000 with waiver of premiums and double indemnity for accidental death included without premium charge.

Since inception of the program, there have been 236 death claims in which a total of $2,400,000 was paid out.

Through the large volume of insurance and strong participation of our members in this program we are able to have non-cancellable term life insurance at a very low cost.

At the present time, over 1800 of our members participate in the program with approx-

imately $28,660,000 of insurance currently in force.

The additional $100,000 coverage through the Bankers Life Company is available to members whether or not they carry insurance under the original program. This will make possible larger amounts of insurance without the necessity of a physical examination and give our members even greater flexibility in establishing their insurance program. The new cost and structure of the Bankers Life Program is quite similar to that of the Nationwide Life Insurance Company described above.

Life Insurance coverage is also available to spouses, children, and employees. Ninety of them participate in this program.

Professional Corporations

E. & W. Blanksteen Agency, Inc., our administrator for the Basic-Extended Long Term Professional Income Protection Plan, Major Expense Plan, Hospital-Money Plan, EPIC Automobile Insurance Plan, Overhead Expense Plan, Life Insurance Plan, and Six-Point High Limit Accident Insurance Plan, advised that all the programs are adaptable for use in professional corporations with necessary assignment forms available upon request.

Recommendations

That the E. & W. Blanksteen Agency, Inc., be continued as the official broker for MSNJ's Accident and Health, Major Expense, Hospital-Money, Life, High-Limit Accident, Automobile Insurance, and Professional Overhead Expense Programs.

Approved (page Tr 129)

Professional Liability

During the past year, the committee has been heavily involved in evaluating and recommending desirable or necessary changes in our current program. We have also conducted in-depth evaluations of several alternate approaches to solving the problems related to professional liability.

No-Fault

One suggested new approach involved the implementation of a no-fault insurance for professional liability—a study directed by the 1972 House of Delegates (Resolution #9).

Our Committee was given the responsibility for a feasibility study of this concept. An extensive analysis of material on various no-fault automobile plans, plus other data, led to the conclusion that no-fault is not readily feasible or adaptable to professional liability. Our position was accepted by the Board of Trustees and a complete report was made to Society members in *The Journal* of February 1973.

Arbitration

Two approaches involving the use of arbitration were also given extensive study. One involved the proposal of an insurance company relatively new to medical professional liability, who expressed interest in a program for the Society. Their proposal included a 10 per cent reduction in rates in exchange for the obtaining of a signed arbitration agreement from each patient in advance of treatment. No rates were actually submitted, so comparison without present premiums could not be made. Failure to obtain a signed arbitration agreement subjected the insured to a deductible of $10,000 per claim. This approach places an onerous burden on the shoulders of each physician, with a substantial financial penalty for failure to perform. In addition, a question exists as to whether any premium savings would actually develop.

Implementation of arbitration has also been suggested by an organization representing another provider of medical services in the State of New Jersey. A pilot project was suggested at a meeting with the Supreme Court's Committee on Relations with the Medical Profession and the Medical Society's Conference Committee with the Bench and the Bar. After much study and deliberation, our committee determined that engaging in any program requiring arbitration was not desirable. This decision was based on analysis of the many

adverse effects which might accrue, plus the paucity of information as to existing programs involving arbitration of professional liability claims, which have yet to prove themselves as a favorable alternative to our present format.

Loss Control Program

Our Loss Control Program continues to be a viable and important element in control of claims and suits. During the past year our committee:

Arranged for distribution of information to the President of each Component Society regarding procedures and rules under which the Medical Review and Advisory Committees operate. This will permit each society to familiarize itself with these important guidelines and better understand the manner in which these committees operate.

Obtained a commitment from Chubb & Son, Inc., (our present insurer) to notify each involved doctor as to the findings of the review committee on his respective claim or suit.

Attended a meeting arranged by the broker for the Society, which included representatives of all of the law firms presently participating in the program and also from Chubb & Son, Inc., to review current legal trends and their effect on medical professional liability.

Responded to specific inquiries for additional information on loss trends and developments.

Surcharge

This phase of our program has been in effect since 1968, and requires payment of additional premiums for those few members having an adverse claim history. In view of the increase in value of claims, due to inflationary trends, our committee recommended that a non-defensible claim shall *not* be considered for surcharge purposes if its value is $3,500 or less. Previously this limitation was $1,000. However, we maintained the rule that claims valued in excess of $1,000 must continue to be submitted to appropriate county medical review and advisory committees.

Rates and Premiums

Premiums for various forms of Professional Liability coverage for our Society have been relatively stable for a number of years. For instance, we have had no increase in Personal Prestige (Umbrella) rates since 1970. During the past year our committee has been involved in rating studies for certain specialties or for special circumstances and recently in evaluating rates for all classes of practice. The following covers two changes that have already been effected mostly of an advantageous nature, plus two additional changes involving future premiums, which reflect anticipated developments:

In 1972, a commitment was obtained from Chubb & Son, Inc., permitting temporary reduction in rates and refunding of premiums for those members who have been completely disabled due to illness or accident. This approach has already resulted in the savings of substantial premiums for our members and will continue to offer similar benefits in the future.

In 1972, an evaluation was made of the experience for psychiatrists including electro-shock therapy, and for hazardous procedures related to the practice of neurology. As a result the following changes were implemented prior to renewal of policies for the 1972-1973 policy year:

Ten per cent reduction in the rate for psychiatry, plus reduction in the rate for electro-shock therapy to one-half the charge applicable to the practice of psychiatry.

An additional charge of 100 per cent of the rate for neurology for those neurologists performing angiograms, arteriograms, and pneumoencephalograms.

As a means of assuring more adequate limits of coverage for Society members, it was agreed the minimum coverage available under the program would be raised to $25,000 each claim and $75,000 aggregate.

Since the Society found it desirable to change to Chubb & Son, Inc., following insistence by our previous insurance carrier for *another* substantial rate increase, our professional liability premiums have seen little change. However, an evaluation of claim and suit data for a ten year period, *related solely to New Jersey experience* resulted in a determination that an increase would be necessary this year. While the experience could support a request for even higher rates, a compromise increase of 25 per cent was submitted. This percentage was obtained by the broker for the Society only after lengthy meetings and discussions with the company. Our Committee carefully analyzed the studies covering the ten years of claim experience. Consideration was also given to alternative courses of action. The Committee considered fluctuating the increase based on the claim experience of each class of practice, and in some instances, the experi-

ence of specialties within the class. Following much discussion, the committee approved a rate increase of approximately 25 per cent, with allocation by class and specialty as follows:

Class	*Specialty*	*Increase Needed to Accomplish Over-all Change*
0	All Specialties	None
7	" "	None
6	" "	10%
1	" "	23%
2	" "	10%
3	" "	15%
4	" "	23%
5—Anesthesiology, Obstetrics-Gynecology, and Plastic Surgery		22½%
5—Neuro-Surgery		22½% plus 50% surcharge of total
5—Orthopedics		22½% plus 20% surcharge of total

Should the Commissioner of Insurance reduce the increase or disapprove it altogether the Company has agreed to continue the program at such rate as the Commissioner determines reasonable.

Recommendation:

That the Joseph A. Britton Agency be continued as MSNJ's Official Broker for its Professional Liability Coverage.

Approved (page Tr 129)

STATEWIDE BLUE CROSS-BLUE SHIELD PROGRAM

Late in 1971, Donald F. Smith & Associates was authorized to negotiate with New Jersey Blue Cross-Blue Shield in regard to establishing a statewide program of Blue Cross-Blue Shield coverage. After completing negotiations with the Blues, Mr. Smith presented a proposal for the program. The proposal was acceptable to the members of the Committee and was referred to representatives of the various County Societies for their review.

Ultimately, ten County Societies elected to join the program effective July 1, 1972. The participating Societies are Atlantic, Burlington, Essex, Gloucester, Mercer, Morris, Salem, Somerset, Sussex, and Warren. Cumberland County originally agreed to join but reversed that decision at a later date. The Camden County Medical Society recently polled their members about the program. As a result, they joined the group as of April 1, 1973.

The new program provides the standard 120-day comprehensive Blue Cross contract plus the Blue Shield 500 Plan and Rider "J" 365. The plan was specifically tailored to meet the needs of today's doctor and his dependents. For example, the coverage is continued for unmarried children up to age 23. This is worthwhile since the children of professional men tend to stay in school longer than the average child. Another plus takes into account the large amount of traveling done by doctors and their dependents. The program pays the full semi-private room rate in non-member hospitals instead of the $30 per day. This provision would come into play most often if an individual were hospitalized while traveling out of the United States. However, there are also a number of non-member hospitals in the States as well. The program also provides the full 120 days coverage for all conditions—including tuberculosis, alcoholism, polio, and contagious diseases. The standard Blue Cross contract only allows 20 days coverage for those conditions.

The participation by the members of the individual County Societies has been excellent. More than 2,000 doctors—both active and retired—are currently covered under the program. This is an increase over the previous combined participation in the individual County Society plans.

The program was originally established on a quarterly billing basis. As soon as the program was established and running smoothly, the participating doctors were given the option to be billed on an annual basis.

The purpose of establishing the statewide program was to provide a better program through the mass purchasing power of a larger group. The first improvement was in the benefit area as mentioned previously. Sec-

ondly, the administration of the program is done through the office of Donald F. Smith & Associates. This means that questions regarding coverage or problems with claims are readily attended to by experts. When the time comes for the annual rate determination, the statewide group will have its rates determined solely on the basis of its own experience rather than being combined with other groups in the State. If our claims experience continues on the present better-than-average basis, this should help keep our rates down.

Filed (page Tr 129)

Medical Education

James A. Rogers, M.D., Chairman, Paterson

(Reference Committee "D")

The Committee on Medical Education has had a very active and productive year. Since the last annual meeting, the Committee engaged in the preparation of material for presentation to the Council on Medical Education of the AMA. This activity was the result of a mandate that the Committee on Medical Education of MSNJ develop criteria to survey continuing medical education activities in New Jersey. The AMA reviewed the criteria, methods, and procedures as presented by your Committee and found them acceptable. In the Fall of 1972, New Jersey was one of the six states that had been approved as a state accrediting body. The area of survey activity of this Committee is the hospitals of the State, institutions, and societies whose programs involve their medical education activities within the State. It does not interfere with those institutions, societies, or hospitals which have been heretofore accredited by the AMA directly.

By now all interested and involved institutions, societies, and hospitals have received information regarding this activity.

The brevity of this report does not reflect the amount of work that has been accomplished by the Committee in preparation for Continuing Medical Education Survey Accreditation. Since the material, describing what is involved, has been distributed and will be later published in *The Journal,* the Committee felt that duplication in the annual report would serve no useful purpose.

Along with other committees and members of MSNJ the Committee on Medical Education has been active in the deliberation and hearing involving the Master Plan of the Department of Higher Education of the State of New Jersey. It has been cooperating as well, with the Office of Continuing Medical Education of CMDNJ, having two representatives of MSNJ on its Advisory Council.

Members of the Committee have actively participated in workshops and in seminars both statewide and nationally regarding continuing medical education.

The Committee is well aware of the amount of participation and increased activity it must undertake in this area and is prepared to proceed.

The Chairman takes this opportunity to express his gratitude to the members of the Committee, the Consultants and to the Staff of MSNJ for the devoted efforts and excellent cooperation.

Filed (page Tr 131)

Medical Student Loan Fund

William Greifinger, M.D., Chairman, Essex

(Reference Committee "B")

In its sixteen years of operation the Medical Student Loan Fund has granted loans totaling $312,144.35, including $444.35 as insurance payments, bringing the net loans granted to $311,700.00.

To date the Fund has issued 286 loans to 172 New Jersey medical students. One hundred loans have been repaid in full. Eighteen borrowers are presently making quarterly repayments on an annual basis.

Requests for financial assistance by New Jersey medical students have increased from twelve in 1971-72 to thirty applications during the 1972-73 administrative year. It is expected that this trend will continue for some time. Out of a total of thirty students' requests, eleven were granted loans of $1,500 and one for $1,400, for a total of $17,900. Eighteen loan applications are still in process.

After satisfying the aforementioned applications, it is estimated that the Fund will have $46,000 available for loans for the 1973-74 school year. Of this amount $27,000 is committed to prior applicants, leaving $19,000 for new student requests. Applications and new inquiries received to date from qualified medical students total $4,500.

This report does not reflect the additional applications expected from other qualified medical students and our Committee is also mindful of the ever-increasing tuition rates. However, at this time, it does not feel the necessity to increase the $1,500 yearly loan limit.

Your Committee has had continued encouraging results from its solicitation of past loan recipients, now serving an internship or residency, to initiate early repayment of their loans on an interest-free basis.

The financial activities of the Fund during the year are included in the report of the Treasurer.

Your Committee warmly commends and thanks Mr. Lambert and Mr. Squreck for their consistently efficient administrative assistance.

Present Location of Recipients of Loans

The 91 graduates are located as follows:

Interns—8 in New Jersey and 6 out-of-state	14
Residents—12 in New Jersey and 15 out-of-state	27
Armed Services—7 Army of the United States and 8 United States Navy	15
Private Practice—4 California, 4 Connecticut, 1 Maryland, 1 Massachussets, 1 Mississippi, 15 New Jersey, 2 New York, 1 North Carolina, 2 Oregon, 2 Pennsylvania, 1 Texas and 1 Virginia	35
Students presently in medical school—10 seniors and 4 juniors	14
Current student loans outstanding	105
Medical students paid in full (100 loans)	67
Total New Jersey Medical Students	172

Contributions

The Committee is grateful to the many contributors to the Fund, and takes this occasion to acknowledge their support. A list of Contributors since the last report follows:

General Fund

The Medical Society of New Jersey, Board of Trustees; MSNJ's Woman's Auxiliary Executive Board; County Medical Societies: Bergen, Burlington, Camden, Cumberland, and Union. County Woman's Auxiliaries: Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Mercer, Middlesex, Ocean, Passaic, Salem, Somerset, Sussex, Union, and Warren. Nicholas A. Bertha, M.D., Dr. and Mrs. James E. Brennan, Dr. and Mrs. Robert A. Cornwell, Dr. and Mrs. David Eckstein, Dr. and Mrs. S. S. Ellenson, Dr. and Mrs. Paul B. Ferrary, Dr. and Mrs. Philip Fiscella, Bea, Leon and Jaye Friedman, Mrs. Anthony

Giannotto, Joseph R. Jehl, M.D., Mrs. Robert Joelson, Dr. and Mrs. Philip Kunderman, Dr. and Mrs. John F. Kustrup, Sr., Dr. and Mrs. Arthur Lawrence, Dr. and Mrs. Samuel J. Lloyd, Dr. and Mrs. Luke A. Mulligan, Mr. and Mrs. Richard I. Nevin, Dr. and Mrs. Paul H. Pettit, Dr. and Mrs. Irving Schnee, Dr. and Mrs. John Scillieri, Dr. and Mrs. Joseph Shapiro, Mrs. Margaret C. Sparks, Dr. and Mrs. Wayne Stewart, Mrs. Lucius Tarchione, Dr. and Mrs. John S. Van Mater, Mrs. H. Roy Van Ness, Mrs. Ethel B. Williams, Dr. and Mrs. Edward A. Wolfson.

In Memory Of

Anthony Ambrose, M.D., Mr. Alfred Baker, Mrs. James N. Barroway, Mrs. Helen Broderick, Joseph Basralian, M.D., Mr. Joseph Berg, Mrs. Ralph K. Bush, Mrs. Thomas Cantalupo, Mrs. Anthony D. Crecca, Mr. Peter Curtis, Mrs. Daisy D. Cutshall, Miss Debbie Davidson, Mr. Samuel DeBoer, Mr. James Dilworth, Mr. Eckstein, Mr. Federico Federici, Mrs. William Finegan, Mr. Samuel J. Flickinger, Sr., Mrs. Louis Freedman, Mr. William Freund, Sr., Mr. Benjamin Gidding, Abraham Goldfarb, M.D., Mr. David Goldstein, Edward R. Gorman, M.D., Mrs. B. M. Howley, Sr., Mr. Louis Izzo, Jerome G. Kaufman, M.D., Joseph M. Kuder, M.D., Dean H. LeFavor, M.D., Lodovico Mancusi-Ungara, M.D., Frank A. Manzione, M.D., Mrs. Anthony Marchigano, Alfred D. Meneve, M.D., Mr. Leslie Mike, Luke A. Mulligan, M.D., Mr. F. Q. Nicholas, Jr., Mrs. Grace L. Olpp, Mr. Andrew O'Sullivan, Louis Perkel, M.D., Herschel P. Pettit, M.D., Frank J. Rose, M.D., Mrs. Mary Elizabeth Rushton, Mrs. Phyllis Shapiro, Mrs. T. Shapiro, Mrs. Louis Stein, Joseph Stokes, Jr., M.D., S. Emlen Stokes, M.D., Lucius Tarchiani, M.D., Mrs. Matilda Townsend, Mrs. Mary Ayres Turner, Frank Vanderbeek, M.D., Mrs. Edna M. Vanderburg, Mrs. Gertrude Fortuin Van Dyke, Mr. Salvatore Vella, Mr. Hubert Windley.

In Honor Of

Mrs. "Mom-Mom" Jacobson, Dr. and Mrs. Rauschenbach, Blackwell Sawyer, M.D., Dr. and Mrs. Shapiro, Eleby R. Washington, M.D., MSNJ's Woman's Auxiliary Executive Board.

Recommendations

(a) That the House of Delegates concur in the recommendation of the Finance and Budget Committee—approving a budget appropriation of six thousand dollars in lieu of a special per capita assessment for 1973-74 in support of the Medical Student Loan Fund.

Approved (page Tr 128)

(b) That the MSNJ membership be urged to continue their active support by sending contributions to the Fund.

Approved (page Tr 128)

(c) That the Woman's Auxiliary to The Medical Society of New Jersey be requested to make the Fund one of its chief projects for next year.

Approved (page Tr 128)

Filed with notation (page Tr 128)

Distribution of Loans

County of Residence	*Medical School*	*Students*	*Loans Granted 1957-72*	*Loans Granted 1972-73 March 31, 1973*
Atlantic	Hahnemann	3	$ 3,000	
	N.J. Medical	1	1,000	
	Pittsburgh	1	2,000	
	Temple	1	1,000	
	Tufts	1	4,000	
Bergen	Boston	1	1,000	
	Creighton	1	1,000	
	Hahnemann	3	5,000	
	Jefferson	2	4,500	
	Loyola	1	3,000	
	N.J. Medical	9	11,000	$ 3,000
	N.Y. Medical	2	2,500	
	St. Louis	2	3,000	
Burlington	Duke	1	4,000	
	Hahnemann	1	1,000	
	Jefferson	3	9,500	
Camden	Jefferson	3	5,000	
	Michigan	1	2,000	
	N.J. Medical	2	2,700	
	Temple	5	7,500	
	Hahnemann	4	6,500	
Cumberland	Jefferson	1	2,000	
Essex	Albany	1	4,000	
	Bern	1	2,000	
	Duke	1	2,000	
	Hahnemann	3	8,000	
	Howard	1	300	

County of Residence	Medical School	Students	Loans Granted 1957-72	Loans Granted 1972-73 March 31, 1973
	Jefferson	1	3,000	
	N.J. Medical	15	26,500	$ 4,400
	N.Y. Medical	2	2,000	
	Stanford	1	3,000	
	St. Louis	1	500	
	Temple	1	1,000	
	Georgetown	1	1,000	
Gloucester	Hahnemann	1	1,000	
	Temple	1	2,000	
	U. of Virginia	1	1,000	
Hudson	Boston	1		$ 1,500
	Georgetown	1	$ 1,000	
	George Washington	1	3,000	
	Hahnemann	1		1,500
	Harvard	1	1,000	
	Howard	1	400	
	N.J. Medical	19	28,650	
	N.Y. Medical	1	1,000	
	Pittsburgh	1	3,000	
	St. Louis	1	2,000	
Mercer	Hahnemann	2	3,000	
	Howard	1	1,000	
	Johns Hopkins	1	1,000	
	Meharry	1	250	
	Mississippi	1	3,000	
	N.J. Medical	5	9,500	
	N.Y. Medical	1	1,500	
	U. of Penna.	1	1,000	
	St. Louis	1	700	
	U. of Louisville	1	4,500	
Middlesex	Georgetown	1	1,500	
	Hahnemann	1	4,000	
	Wisconsin	1	1,500	
Monmouth	Columbia	1	2,000	
	Duke	1	3,000	
	Georgetown	1	1,000	
	Jefferson	2	6,000	
	Marquette	2	3,500	
	Med. Coll. of Pa.	1		$ 1,500
	N.J. Medical	3	10,000	
	N.Y. Medical	1	4,000	
	Loyola, Stritch	1	4,500	
	Temple	1	2,000	
	Up-State N.Y.	1	1,000	
Morris	Dartmouth	1	1,000	
	Duke	1	1,000	
	Loyola, Stritch	1	1,500	
	N.J. Medical	1	3,000	
Ocean	U. of Penna.	1		1,500
Passaic	Jefferson	1	3,000	
	N.Y. Medical	1	1,000	
	Wisconsin	2	3,000	
Salem	Duke	1	1,500	
	Jefferson	1	1,500	1,500
Somerset	Georgetown	1	1,000	
	N.Y. Medical	1	2,000	
	Temple	1	3,000	
	Western Reserve	1	1,000	
Union	Florida	1	1,000	
	Hahnemann	1	1,000	
	Jefferson	1	1,500	
	N.J. Medical	11	17,800	1,500
	N.Y. University	1		1,500
17 Counties	33 Medical Schools	172	$293,800	$ 17,900
Total loans granted 3/31/73				$311,700

Publication

Daniel B. Roth, M.D., Chairman, Teaneck

(Reference Committee "B")

Despite rising costs we have been able to continue to publish a superior journal. Total pages for 1972 were up slightly over 1971 There was also a slight increase in advertising, which represents an increase in "local income." National advertising is down.

Year	Text	Advertising	Total Pages
1970	752	556	1308
1971	737	495	1232
1972	741	534	1275

Expenses were up.

EXPENSES OVER INCOME
(ADJUSTED)

1969-70	$28,163.
1970-71	33,427.
1971-72	35,691.
1972-73	37,000. (projected)

Most of this is covered by the subscriptions paid as part of dues and advertising income. The rest is covered out of the Society's general funds.

Your Committee has discussed the increasing expense but there does not appear to be much we can do about it, and the Society will have to continue to make up the deficit. National advertising revenues can be expected to dwindle. Printing and operating costs are increasing and can be expected to continue to do so. One avenue can be explored: regionalization, i.e., amalgamation with several other states to publish one journal instead of a number of individual ones. There are pros and cons to this idea, but it warrants further study.

Our *Journal* has run very well over the years with a very modest staff, but the time has come when our staff must be enlarged. Dr. Henry A. Davidson, our Editor-in-Chief, has served us well over the past thirty-two years, but he now needs help. We plan to appoint several associate editors to assist him. Likewise, Mrs. Treptow, our Assistant Editor, who does an excellent job, also needs a back-up and we anticipate the appointment of another staff member to *The Journal* office.

The Publication Committee wants to thank Dr. Davidson, Mrs. Treptow, and Mr. Cookson, our Advertising Manager, for a job well done. We hope they will be able to continue for many more years.

Filed with notation (page Tr 128)



Officers' Dinner—l to r, Mrs. Bertha, Dr. Bertha, Mr. Nevin, Mrs. Rogers, Dr. Rogers, Mrs. Nevin

Revision of Constitution and Bylaws

Hillel M. Ben-Asher, M.D., Chairman, Morristown

(Reference Committee on Constitution and Bylaws)

The Committee had several proposals before it and dealt with each in accordance with the Bylaws.

Proposed Amendment to the Constitution (Affiliate Membership)

The following proposed amendment to the Constitution was accepted by the House of Delegates at the 1972 Annual Meeting, recognizing that such amendment must be considered by the House of Delegates for final vote in 1973. The procedure outlined in Article XII, B, 10 has been complied with.

This proposed revision requires adoption by a two-thirds vote of the members of the 1973 House of Delegates present and voting at the final session.

Recommendations

That the following amendment to the Constitution be adopted.

Article IV—Organization of the Society
Section 1—Composition

Current	*Proposed*
This Society shall be composed of Fellows, Officers, Delegates, members, and associate members of component societies in good standing and Emeritus Members. Honorary Members may be elected, but they shall not be members of the corporate body.	Same
	Affiliate Membership may be granted but recipients may neither vote nor hold office.
	Section 8—Affiliate Members
	Affiliate Members shall be physicians who have been active members for at least five consecutive years but who no longer practice in New Jersey. Applications for Affiliate Membership shall be directed, through the component medical society, to the Standing Committee on Medical Defense and Insurance of The Medical Society of New Jersey for consideration and action. Affiliate Members shall be eligible to continue all insurance coverages offered by the Society except those relating to professional liability. The dues for Affiliate Members shall be established by the House of Delegates on recommendation of the Committee on Finance and Budget.

Adopted (page Tr 125)

Proposed Amendment to the Bylaws Continuing Medical Education

Various issues of the proposed educational program were discussed. It was noted that the 150 hours in a given three-year period will be easily attainable by the practicing physician in attending staff meetings, teaching clinics, and rounds, etc. The methodology to be employed is that the member will apply to the AMA for the Physician's Recognition Award. The AMA will notify our Committee on Medical Education as to the member's eligibility. Applications by AMA members and non-members will be processed in the same fashion. Reciprocity and exemptions shall be granted where indicated. The Committee **recommends** the amendment proposed in Exhibit #1 for adoption.

Exhibit #1

Chapter XI—Component Societies

Section 2—Qualifications of Members

Current	*Proposed*
(a) Component societies shall have the responsibility to judge the qualifications of an applicant for any type of membership and alone shall have the power to elect him, but election thereto shall be con-	Same

tingent upon clearance of each eligible applicant's formal credentials as satisfactory by the Committee on Credentials of this Society.		
(b) To be eligible for membership, the applicant must:	Same	
(1) be a citizen of the United States or have filed with the State Board of Medical Examiners a formal declaration of intent to become a citizen;		
(2) hold a degree in medicine acceptable to this Society obtained from a medical school approved by this Society at the time of his graduation;		
(3) be fully licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners;		
(4) be legally registered under that license in a county of New Jersey;		
(5) be of good moral and ethical standing; and		
(6) not support, or practice or claim to practice any exclusive system of medicine.		
(c) When a physician applies to a component society for membership in any category, or for membership by transfer from another state, the secretary of the component society shall forward the name and address of the applicant to the biographic department of the American Medical Association for such information as may be on file relative to the applicant's record.	Same	
(d) All records of formal actions concerning new and transfer members shall be compiled on forms to be supplied by the Committee on Credentials.	Same	
	(e) In order to retain active membership in this Society the member must hold a current Certificate in Continuing Medical Education from MSNJ's Committee on Medical Education. This certificate will be bestowed upon members who satisfactorily complete acceptable programs of continuing education for a total of 150 hours in a given three-year period. This program is to be administered by the Committee on Medical Education in accordance with policy approved by the Board of Trustees and affirmed by the House of Delegates. The Committee on Medical Education may, with the approval of the Board of Trustees, and for good cause shown, grant specific exemptions to this subsection.	

Foregoing (e) amended by the House by deletion of the word "satisfactorily" in the 10th and 11th lines of the paragraph (page Tr 125)

Adopted as amended by the House (page Tr 125)

Proposed Amendment to the Bylaws
AMA Delegates

In order to effect the intent of Resolution #1 as adopted by the 1972 House of Delegates, the Committee **recommends** the following amendment to paragraph (a) Chapter VIII of the Bylaws be adopted.

Exhibit #2

Chapter VIII—Other Delegates and Representatives

Current	*Proposed*
Delegates and Alternate Delegates to other medical organizations shall be elected in accordance with the provisions of Chapter V of these Bylays.	Same
(a) American Medical Association. The terms of office of Delegates and Alternate Delegates shall begin on January first of the year following their election, and shall continue for two (2) years, ending on the second December 31 thereafter.	Same
In the absence of any Delegate, any Alternate Delegate shall be eligible to serve.	Same
	No member shall serve more than three two-year terms as an AMA Delegate. Likewise, no member shall serve more

	than three two-year terms as an Alternate Delegate.
(b) Other Medical Organizations. When representation has been recommended by the Board of Trustees and approved by the House of Delegates, such Delagates and Alternate Delegates shall be elected for terms of one (1) year.	Same
(c) Representatives. Official representatives from this Society to other organizations shall be appointed by the Board of Trustees or by the President with the approval of the Board of Trustees. Their functions and terms shall not exceed those set forth in their official notice of appointment.	Same

Adopted (page Tr 125)

PROPOSED AMENDMENT TO BYLAWS

MEMBERSHIP FOR INTERNS AND RESIDENTS
(ELIMINATION OF THE CATEGORY OF
"ASSOCIATE MEMBERSHIP" AS
PRESENTLY CONSTITUTED)

The House of Delegates in adopting Resolution #3—1972—took the position that a category of membership, other than active, should be established for interns and residents. The Board of Trustees, at its September 17, 1972 meeting, adopted a motion calling for the elimination of the category of "associate membership" and the transferring of that designation to interns and residents. This Committee concurs in the policy adopted by the Board of Trustees, and in an effort to effectuate that decision offers and **recommends** the following proposed amendment to Chapter XI, Section 4 of the Bylaws.

Exhibit #3

Chapter XI—Component Societies
Section 4—Associate Members

Current	*Proposed*
(a) Except in the case of transferred membership, each component society must require applicants to serve a probationary period of one (1) to two (2) years as associate members.	*(a) Associate members shall be those physicians admitted to component societies who otherwise comply with Section 2 of this chapter but are not licensed to practice medicine and surgery in New Jersey but are serving in approved internship or residency programs.*
(b) Associate members shall have such privileges in component societies as the constitution and bylaws of the respective societies may provide, except the right to vote and hold office.	(b) Same
(c) Associate members shall be assessed the current per capita assessment.	*(c) The dues for associate members shall be established by the House of Delegates on recommendation of the Committee on Finance and Budget.*

Adopted (page Tr 125)

(By the adoption of the above amendment current Associate Members shall automatically become active members and a new class of Associate Membership is being created.)



Speaker of the House
Henry J. Mineur

Woman's Auxiliary Advisory

William J. Roe, M.D., Chairman, Englewood
(Reference Committee "H")

At its July 1972 meeting, the Board of Trustees approved the proposed program of the Woman's Auxiliary for 1972-1973 as submitted. Because the work of the Auxiliary was so well planned and so smoothly carried out there was no need for a formal meeting of this Committee during the course of the administrative year.

At the request of the Auxiliary President, the Dean of the Rutgers Medical School, and the Associate Dean of Research and Sponsored Programs of the New Jersey Medical School, Newark branch, were present at an Executive Board meeting to explain their use of AMA-ERF Funds.

After attending the conference on the Quality of Life in Chicago last fall, members of the Woman's Auxiliary began to wonder about the quality of health education in our own state. A committee met with the Director of Curriculum in the State Department of Education and from him learned that most health education classes were taught in gym classes by gym teachers who had specialized training in physical education but practically none in health education. We also learned that our state teacher colleges had only one three-hour course in health education, which could be waived by passing a simple true-false test.

Arrangements were then made for a committee of two Auxiliary members and a doctor representing the Medical Society to meet with the State Board of Education. We voiced our concern over the poor quality of health education in our schools and urged the mandatory use of school nurses and teachers trained as health educators to present a health education program consisting of nutrition, mental health, hygiene, communicable diseases—particularly venereal diseases on the secondary education level, first aid, ecology, and alcohol, tobacco, and drug information beginning on the elementary level. Our presentation was very well received by the State Board, and we were assured that they shared our concern and would carefully study our proposals.

We are following this up by scheduling a meeting with a representative of the Department of Higher Education in an effort to improve the scope and quality of courses given in our state colleges to educate future health educators.

Auxiliary members have volunteered many hours of their time to aid communities in cancer detection clinics, drug education programs, day-care centers, health careers, and the distribution of sample medications. Many social events have been utilized to raise funds for Medical Student Loan Fund, AMA-ERF, and nurse and health career scholarships.

Filed with commendation to the Auxiliary (page Tr 139)



Speakers Platform—House of Delegaes

Administrative Council

Legislation

Henry J. Mineur, M.D., Chairman, Cranford
(Reference Committee "E")

This report presents a summary of the ultimate status of legislative measures of primary concern to the Society in the 1972-73 Legislature.

The Council's operations, together with a cumulative report of MSNJ's official positions on current legislation, are reflected regularly in official bulletins dispatched to State Legislative Keymen and to component societies, and in items published in the *Membership Newsletter* and *The Journal*. The minutes of the meetings of the Board of Trustees include full reports of the Council's actions taken in regular meetings.

The Council on Legislation continues its established policy of inviting an official representative from each specialty society to all Council meetings.

Although a notice announcing the date of each of the Council's meetings is sent to all MSNJ's official intermediaries with New Jersey specialty societies, the attendance of those representatives at the Council meetings remains small. The Council urges that more representatives attend its meetings so that it may have the benefit of the timely thinking of specialty societies concerning proposed legislation affecting the specialty fields.

Of the bills reported to the House in 1972, the following were signed into law:

APPROVED: S-3, S-253, S-508, S-544, S-841, A-121, A-255, A-415, A-420, and A-826

DISAPPROVED: S-132—To provide that it shall be a disorderly persons violation for anyone to abandon any disposable or re-usable hypodermic needle or syringe without first destroying it.

N.B. No bills given ACTIVE SUPPORT or ACTIVE OPPOSITION had been signed into law at the time of compilation of this report.

Current State Legislation

In the afternoon of 9 January 1973 the Second Annual Session (1973) of 195th New Jersey Legislature was opened. As the Legislature presently is constituted, the Senate has a total of 40 members. Two seats are vacant and the Senate presently is made up of 22 Republicans and 16 Democrats. The Assembly has a total of 80 members of whom 39 are Republications, 40 are Democrats and 1 is an Independent. By means of official legislative bulletins the Society's official positions on all current State Legislation are regularly called to the attention of legislators as well as to component societies, cooperating agencies, county keymen, and county society secretaries and executive secretaries.

The Society has adopted the following regular range of official positions concerning proposed legislation:

ACTIVE SUPPORT—All-out support for the measure

ACTIVE OPPOSITION—All-out opposition to the measure

APPROVAL—Commended as satisfactory, but not actively supported

CONDITIONAL APPROVAL—To indicate that the approval of the Society is conditional subject to the elimination of the unsatisfactory elements of the bill that are pointed out

DISAPPROVAL—Rejected as unsatisfactory, but not actively opposed

NO ACTION—Considered, but not regarded as significant or relevant to the proper interest of the Society

All measures thus marked (*) are identical with bills of last year—or preceding years—whose official positions were the same.

S-850 —To provide that the rules and regulations of the State Board of Education concerning school buses shall include requirements for school bus safety seats. *APPROVED*

S-851 —To provide that every school bus transporting children to and from school shall be equipped with emergency exits. *APPROVED*

S-852 —To require that every school bus transporting children to and from school shall be staffed with a monitor at least 16 years of age. *DISAPPROVED,* because the Department of Education has reported that the cost and the administrative impracticalities of the measure make it undesirable legislation.

Referred back to Council on Legislation for reconsideration (page Tr 132)

S-858 —To require health insurance to disclose, in clear and concise language, specified items about policies they are selling in order that the consumer may make an informed decision concerning his purchase of health insurance under the New Jersey Health Insurance Disclosure Act. *DISAPPROVED,* because while MSNJ approves the intent of the first portion of the bill to make policy language simple and clear, it is of the opinion that the bill goes too far and would only confuse the subscriber and impose unnecessary administrative burdens on the Commissioner of Insurance.

S-876 —To provide that leaves of absence shall be granted classified civil service employees for the purpose of donating blood. *APPROVED*

S-877 —To provide that leaves of absence shall be granted State employees for the purpose of donating blood. *APPROVED*

S-878 —To provide that general public assistance shall be included in the current state-operated medicaid health care benefits program. *APPROVED*

S-885 —Permits the Commissioner of Institutions and Agencies to make such investigations as he deems necessary in the administration of the Department. *NO ACTION*

S-889 —To provide that the medical assistance program shall include the cost of drugs prescribed for persons 65 years of age and older, not otherwise eligible for assistance, who are determined by the Commissioner of Health to need such financial assistance. *APPROVED*

S-890 —To provide immunity to volunteer fire and first-aid companies and rescue and emergency squads providing service for control of fires or emergency first aid and rescue services from civil liability to respond in damages. *APPROVED*

S-892 —To prohibit the sale of children's automobile seats which do not conform to the Federal Motor Vehicle Safety Standards for children's seats and harnesses and do not have affixed a date of manufacture label with instructions for proper installation. *APPROVED*

S-893 —To provide for the care and treatment of alcoholism under the New Jersey Comprehensive Intoxication and Alcoholism Control Act; to create a Division of Alcoholism Control in the Department of Health and to appropriate $1,500,000. *APPROVED*

S-912 —To provide for regulation and licensing of persons engaged in a mail order drug distribution business. *APPROVED*

S-919 —To provide that any applicant for renewal of a practical nursing license, originally granted by waiver, who can show 12 years of full-time experience shall be granted a license. *DISAPPROVED,* because it imposes greater restrictions that presently exist upon those LPN's who wish to return to the practice of their profession.

S-950 —To regulate the sale of patent medicines containing antihistamines, belladonna, alkaloids, phenobarbital or its salts, alcohol 5% or higher, ephedrine or its salts, caffeine of 35 milligrams per pill termed non-prescription drugs. *DISAPPROVED,* because this bill would not restrict the availability of the medicines but would increase their costs to the patient.

S-965 —To provide that any person who hypnotizes or attempts to hypnotize another for any purpose including entertainment, except in the practice of medicine, is a disorderly person. *APPROVED*

S-966 —To regulate the practice of dentistry. *DISAPPROVED,* because it would impose excessive powers in the Board of Dentistry and would enable them to set up broad and oppressively detailed bureaucratic regulations which would prohibit or unduly limit the licensed practitioner's right to exercise and be guided by his own best professional judgment.

S-976 —To include under the act concerning sale or possession of hypodermic syringes, needles or instruments the use thereof adapted for the use of controlled dangerous substances. *APPROVED*

S-977 —To provide that any person who possesses controlled dangerous substances for imminent use is a disorderly person. *APPROVED*

S-980 —To define "qualified applicant" under the New Jersey Medical Assistance and Health Service Act to include in determinations of eligibility assistance under this program the chronic and recurring medical expenses of the family unit as a component of the standard of need. *APPROVED*

S-997 —To provide that any person who sells, distributes, or dispenses morphine, cocaine, heroin, opium or any derivative thereof classified in Schedules I or II of the Controlled Dangerous Substances Act and who is not addicted thereto shall be guilty of a high misdemeanor and subject to a maximum imprisonment of 25 years without reduction of a sentence or eligibility for parole. *APPROVED*

S-998 —To permit minors to consent to treatment and care by a hospital, public clinic or a physician when executed by a minor who is or believes he is suffering from drugs and to prohibit later disaffirmance. *APPROVED*

S-999 —To provide that if the weight of alcohol in a defendant's blood is 0.07% or more, it shall

be presumed that his ability to operate a motor vehicle was impaired. *DISAPPROVED,* because The Medical Society of New Jersey favors the criterion proposed in A-719.

S-1000 —To provide that the State Commissioner of Health or a member of his staff designated by him shall be a member of the Clean Air Council. *APPROVED*

S-1007 —To permit sending of handicapped pupils to privately operated day school instructional programs. *APPROVED*

S-1037 —To require all State executive departments to establish and maintain comprehensive occupational safety and health programs. *APPROVED*

S-1041 —To regulate the practice of ophthalmic dispensing. *APPROVED*

Referred back to Council on Legislation for reconsideration (page Tr 132)

S-1054 —To provide for testing of motor vehicle fuels to determine the presence of factors which may contribute to air pollution. *NO ACTION*

Referred back to Council on Legislation for reconsideration (page Tr 132)

S-1055 —To permit pharmacists to use discounts or rebates in sales of drugs or medications to disabled persons or those 65 years of age or older. *APPROVED*

S-1062 —To prescribe safety standards for youth camps. *APPROVED*

S-1079 —To provide that permits of mass gatherings will only be issued when the Board is satisfied that such gatherings will be conducted in compliance with established rules and regulations and the public health, safety, and welfare. *APPROVED*

S 1080 —To provide that need for the carrying of firearms shall be shown when an applicant states he is in a business or occupation which makes it necessary to be out late at night in a high crime area with valuables or medical supplies and drugs. *APPROVED*

S-1094 —To provide for defining and establishing child development centers and for licensing. *NO ACTION*

S-1106 —To provide that any person subject to re-
A-1504 current seizures, such as epilepsy, who has not had such a seizure for a period of one year shall be permitted to obtain a driver's license. *DISAPPROVED,* because under existing law that decision rests with the discretion of the Director and this discretion can be tested in the courts.

S-1109 —To permit the Bureau of Children's Services to provide protective custody of abused children. *APPROVED*

S-1111 —To provide for sending of handicapped children to privately operated schools. *APPROVED,* LAW c.4 (1973)

S-1133 —To provide that no dentist shall administer a local or general anesthetic unless the State Board of Registration and Examination has certified that he had successfully passed a course in anesthesia or an examination conducted by the Board. *DISAPPROVED,* because the legislation is unnecessary inasmuch as the State Board of Dental Examiners can deal with this matter by means of regulation.

S-1134 —To establish the Department of Human Services Act, to appropriate $100,000 and to transfer to such department all functions of the Department of Institutions and Agencies, Division of Public Welfare, Divisions of Mental Health, Mental Retardation, and Drug Abuse. *APPROVED*

S-1165 —To require that one member of the Board of Nursing shall be a representative of the New Jersey Industrial Nurses Association. *NO ACTION*

S-1198 —To provide that nothing in the Act concerning Health Care Facilities Planning Act shall be so construed as a delegation of authority to control charges made by health care facilities for services rendered except as otherwise provided. *ACTION DEFERRED,* pending further information from the New Jersey Hospital Association.

S-1199 —To provide that nothing in the Act concerning Health Care Facilities Planning Act shall be so construed as to require issuance of a certificate of need or to compel an increase or reduction of existing licensed beds for replacing existing beds by new construction. *DISAPPROVED,* because it would, in large part, defeat the purpose of existing law and the use of the procedure of the certificate of need.

S-1200 —To provide that no certificate of need shall be issued or denied without approval of the Board and in the event an adverse recommendation has been issued by the State Health Planning Council, the applicant shall receive notice and be granted an opportunity for hearing. *APPROVED*

S-1217 —To provide for disposition of cases of child abuse and neglect and to create a study commission therefor. *DISAPPROVED,* because it complicates, without improving, existing law procedures.

S-1232 —To provide for retention of photographic reproduction of x-ray films by the hospital custodian of records for a period of five years. *APPROVED*

S-1233 —To provide that no person shall be denied eligibility for Medical Assistance and Health Service Act benefits solely on the basis of increased Social Security benefits payable on or after September 1, 1972. *APPROVED*

S-1238 —To establish a grant program in the Department of Agriculture to supplement the hog cholera eradication indemnity program; to appropriate $130,000. *NO ACTION*

S-1262 —To increase the monetary factor of determining State reimbursement for community

mental health projects from 50¢ to $1 multiplied by the population exclusive of capital expenditures. *NO ACTION*

S-1264 —To permit destruction of hypodermic needles by mangling and other methods not presently provided for. *APPROVED*

S-1265 —To provide that any board of education in a school district in which children are domiciled in a public or private institution by referral from a State or county agency and attend public schools of the district may submit a request for special State aid to the Commissioner of Education. *NO ACTION*

S-2008 —To establish pilot projects in emergency mobile intensive care and to utilize mobile intensive care paramedics. *APPROVED*

S-2009 —To provide that the office of Emergency Medical Service in the Department of Health shall establish a program for training of emergency medical personnel in the procedure of defibrillation. *APPROVED*

S-2043 —To provide that no person having jurisdiction over potable water shall direct mandatory fluoridation until the question has been first approved by voters in a referendum. *DISAPPROVED,* because it is a practical impossibility to achieve, by referenda, the mandatory fluoridation of the water supply of counties when many of them are serviced by a single company. For this reason The Medical Society of New Jersey, since 1971, has been on record as favoring the fluoridation of potable water supplies by means of a mandatory program under the aegis of the Department of Environmental Protection.

S-2052 —To create drug work treatment centers and to provide for commitment and care of hard drug violators. *NO ACTION*

S-2056 —To permit counties and municipalities to provide for hospitalization contracts which include dental and ophthalmological services and supplies. *APPROVED*

S-2059 —To appropriate $500,000 to the Department of Agriculture for Hog Cholera Eradication. *APPROVED*

SJR-2001—To request the Division of Motor Vehicles to provide space on the driver's license for information concerning donations under the "Uniform Anatomical Gift Act." *APPROVED*

SR-25 —To memorialize the President of the United States and the Administrator of Veterans Affairs to give consideration to the establishment of a new veterans' hospital in southern New Jersey. *APPROVED*

A-52 —To provide for exhaust emission standards which must be met in inspections of motor vehicles. *APPROVED*

A-433 —To provide that the Commissioner of Environmental Protection shall formulate rules and regulations concerning the labeling and prohibiting, conditioning, and controlling the sale of cleaning agents whose use may tend to cause adverse effects on man or the environment. *APPROVED*

A-514 —To provide for the regulation of clinical laboratories in the New Jersey Clinical Laboratory Improvement Act. *ACTION DEFERRED,* pending further study of the bill.

A-539 —To provide under the Air Pollution Control Act that noise shall be considered an air contaminant and at a level greater than 108 perceived noise decibels shall be a prima facie evidence of air pollution. *APPROVED*

A-836 —Requires every school bus to be staffed with a monitor at least 16 years of age in addition to the driver; effective at the commencement of the school year next succeeding enactment. *DISAPPROVED,* because the Department of Education has reported that the cost and the administrative impracticalities of the measure make it undesirable legislation.

Referred back to Council on Legislation for reconsideration **(page Tr 132)**

A-961 —To provide for a mandatory seven day jail sentence for a first violation of the drunk driving statute and a mandatory 21 day sentence for a subsequent offense and to reduce the presumption measure of intoxication from 0.15 per cent to 0.12 per cent. *APPROVED*

A-975 —To provide that when a local board of health adopts more stringent health or environmental protection ordinances or regulations than imposed by the Department of Environmental Protection it must obtain the approval of the Department. *APPROVED*

A-976 —To provide that the certificate of serological test required of couples applying for a marriage license shall indicate whether such couples are or are not positive carriers of sickle cell anemia. *DISAPPROVED,* because this legislation would impose an unjustifiable added "pre-marital" test on all that would be of use and significance to comparatively few, at a time when its effect would be minimal, since the test should be done in the period of pre-adolescence.

A-977 —To provide that treatment for drug abuse consented to by a minor shall not be subject to later disaffirmance and shall be reported only as required by the Controlled Dangerous Substances Registry Act. *APPROVED*

A-992 —To provide that all persons aged 65 or over employed as school crossing guards must undergo an annual physical and mental examination. *DISAPPROVED*

A-1002—To establish a division of alcoholism in the Department of Health, to create an advisory council to provide for licensing of alcoholic treatment facilities, to prescribe procedures concerning arrest of an intoxicated person, to authorize establishment of a service force, and to repeal and prohibit municipal ordinances prescribing penalties for public intoxication. *APPROVED*

A-1008—To provide that the Commissioner of Health, with the advice of the committee, shall de-

termine the total number of persons eligible for chronic renal disease care and treatment and shall include a sum necessary to carry out the provisions of this act in his annual budget. *APPROVED*

*A-1019—To authorize the Commissioner of Environmental Protection to promulgate rules and regulations necessary to prevent the treatment and disposal within this State of solid waste collected outside this State. *APPROVED*

A-1024—To create the Genetic Disease Information and Prevention Act of 1972 in supplementation of the act concerning marriage. *DISAPPROVED,* because although MSNJ approves the intent of the bill, it is presently untimely, over-simplified, and impractical of implementation because of lack of competent personnel and facilities.

A-1027—To provide for licensing and regulating of pest control operators and to establish standards for fumigation under the New Jersey Pest Control Act. *APPROVED.*

A-1032—To provide that any person who denies medical treatment to an inmate of a correctional institution leading to the death of such inmate shall be guilty of murder in the first degree. *DISAPPROVED, WITH ACTIVE OPPOSITION IF THE BILL MOVES,* because it would subject a person to the charge of murder on the basis of a simple human error of judgment.

A-1034—To require psychological testing of county and State correction officers as a condition of employment. *APPROVED*

A-1048—To prohibit manufacture, sale or distribution of recycled paper, cardboard or paper products intended for use as containers or wrappers for food products. *NO ACTION.*

A-1053—To provide that acts of abortion by a licensed physician shall be justified within 20 weeks of commencement of the pregnancy where it is necessary to preserve life. *DISAPPROVED,* because the bill is at variance with the policy position taken by the House of Delegates in May, 1972.

A-1054—To provide that acts of abortion by a licensed physician shall be justified within 17 weeks of the commencement of pregnancy where it is necessary to preserve life. *DISAPPROVED,* because the bill is at variance with the policy position taken by the House of Delegates in May, 1972.

A 1055—To authorize the Commissioner of Environmental Protection to limit treatment and disposal within the State of solid waste collected outside of the State. *APPROVED*

A-1063—To increase the membership of the Advisory Council on Solid Waste Management from 11 to 13, including the Secretary of Agriculture and the Dean of the College of Agriculture and Environmental Services of Rutgers University. *APPROVED*

A-1095—To authorize the Commissioner of Education to contract with public and private agencies or clinics for experimental pre-school education programs for handicapped children. *APPROVED*

A-1097—To establish the Handicapped Children's Recreational Opportunities Act. *NO ACTION*

A-1103—To provide that on or after September 1, 1973 school buses shall be equipped with a speedometer, odometer, audible or visible signals to indicate excessive speed. *NO ACTION*

A-1111—To provide for the New Jersey Health Care Facilities Financing Authority Law. (Same as S-841-1972) *APPROVED*

A-1115—To provide that persons afflicted with tuberculosis shall not leave a hospital against the advice of the treating physician or until a release is signed by the treating physician. *APPROVED*

A-1121—To provide that any person, except a licensed physician, who uses hypnosis for clinical treatment to relieve a person from symptoms of illness or unwanted habits is a disorderly person. *APPROVED*

A-1132—To control and regulate the treatment and disposal within the State of solid and liquid waste collected outside the State and to authorize the Commissioner of Environmental Protection to adopt rules and regulations. *APPROVED.* LAW c. 39 ('73)

A-1133—To provide that any seller of age 18 and not addicted to the use of morphine, cocaine, heroin, opium or any derivative thereof shall, upon conviction, be punished by death. *NO ACTION*

A-1134—To require that every bicycle frame, fender, front fork and other parts shall be treated with luminous paint to increase visibility when in use at night. *APPROVED*

A-1163—To authorize the State Board of Nursing to issue licenses for professional and practical nursing to former medical corpsmen of the United States armed forces who have successfully completed courses of instruction required to qualify for a rating of medical service technician. *APPROVED*

A-1168—To define "school" under the act concerning drug education to include grades kindergarten through 12th grade.—*APPROVED*

A-1179—To provide for licensing of audiologists and speech pathologists by the Board of Medical Examiners and to create an Examining Committee of Audiology and Speech Pathology. *DISAPPROVED,* because the bill does not provide that the audiologist is to function at the direction or prescription of a duly licensed physician.

A-1192—To permit the Director of Buildings and Construction, after consultation with the Director of the Rehabilitation Commission, to grant contracting authorities a waiver of any of the requirements imposed by the act to

provide, in public buildings, facilities for the physically handicapped.—*DISAPPROVED*, because the Society has supported, as sound and desirable, legislation to provide facilities, in public buildings, for the physically handicapped. It maintains that position.

A-1195—To provide that regulations of the Board of Education concerning construction and equipment on buses shall include requirements for padding all metal bars on seat backs with energy-absorbing material. *APPROVED*

A-1198—To permit the county prosecutor to refer defendants, with their consent and who have not previously been convicted of any crime, to a program of supervisory treatment.—*APPROVED*

A-1202—To prohibit sale of baby foods containing monosodium glutamate and to provide that the rim of the cover of the container of baby food shall be completely enclosed in a metallic or plastic strip. *APPROVED*

A-1204—To permit taking of children into protective custody when the child has suffered physical injuries and the person suspected of inflicting is a person into whose custody the child would be normally returned. *APPROVED*

A-1251—Amends the Sales Tax to include certain professional services. *NO ACTION*

A-1293—To amend the "New Jersey Medical Assistance and Health Services Act." *NO ACTION*

A-1295—Repeals the Unincorporated Business Tax Act. *APPROVED*

A-1317 —To provide that an impounded animal shall be destroyed only by a method generally acceptable to the veterinary medical profession. *APPROVED*

A-1321 —To exclude from the old age assistance law definition "lacks adequate support" all expenditures for medical services and prescription drugs for treatment of a chronic recurring nature in excess of 30 per cent of an applicant's income and resources and shall not be included for any determination of available income. *APPROVED*

A-1322 —To permit freeholders to establish county boards of health under a Local Health Services Act. *APPROVED*

A-1333 —To require all packaged baked goods to bear a label indicating the date on which they were baked. *NO ACTION*

A-1344 —To prohibit sales of dogs for purposes of experimentation. *DISAPPROVED*, because it would hinder progress of scientific animal research, with jeopardy to the public welfare.

A-1352 —To remove from the Administrative Procedure Act all agencies with management and operation responsibility of State educational, medical, mental, rehabilitative, custodial, penal or correctional institutions or programs insofar as they relate to internal affairs. *NO ACTION*

A-1358 —To provide for the establishment of county residential treatment centers for emotionally disturbed children. *DISAPPROVED*, because the provision of treatment by qualified medical personnel is not specifically insured; nor does it make provision for a certificate of need, which would apparently be required.

A-1374 —To permit minors 14 years of age or over to work outdoors for establishments where alcoholic beverages are served. *NO ACTION*

A-1376 —To establish an Ecology Corps in the Department of Environmental Protection. *NO ACTION*

A-1387 —To provide that persons accused of offense found to be insane shall be ordered into the custody of the Commissioner of Institutions and Agencies for placement in a State institution. *APPROVED*

A-1394 —To empower the Commissioner of Environmental Protection to adopt rules and regulations to control and prevent the accidental spillage of materials which may cause adverse effects on the waters of the State. *APPROVED*

A-1397 —To require persons licensed to give eye examinations to notify the Director of Motor Vehicles whenever persons examined suffer from uncorrectible visual deficiencies. *DISAPPROVED*, because although the intent of the bill is commendable it lacks adequate specific standards for implementation.

A-1403 —To define "hazardous substance" under the Hazardous Substances Labeling Act to include any substances which yield quantities of lead, cadmium or toxic metals, or metallic substances, in excess of standards adopted by the Department of Health pertaining to substances used to contain, store or serve foods, beverages or drink for human consumption. *APPROVED*

A-1413 —To establish a Division of Consumer Health Services and and Advisory Council on Consumer Health in the Department of Health. *DISAPPROVED*, because this legislation is unnecessary in view of existing law.

A-1423 —To provide that all packaged ground meat must be labeled with the day of the week and the month it was ground. *NO ACTION*

A-1434 —To permit municipalities to appropriate funds for use of nonprofit organizations caring for mentally retarded, brain injured, or mentally ill persons. *APPROVED*

A-1442 —To permit the Department of Health to provide appropriate laboratory services for the diagnosis of sexually transmitted diseases, to provide appropriate treatment and to promulgate fees therefor. *DISAPPROVED*, because the imposition by the Department of Health of fees for these services would be inimical to the public health and welfare, especially in view of the fact that in New Jersey we are now in the midst of a venereal disease epidemic.

A-1444 —To prohibit the use of tractionized or regrooved tires on school buses. *APPROVED*

A-1474 —To provide that no dog licenses shall be issued unless the owner provides evidence that the dog has been inoculated with anti-rabic vaccine. *DISAPPROVED,* because the bill is not equitable in that it provides no exemption for dogs allergic to the vaccine.

A-1478 —To provide for direct billing by the providers of clinical laboratory services to the recipient of the services. *DISAPPROVED,* because it would raise the cost of laboratory fees by necessitating the addition of billing and collections procedures.

A-1480 —To require all persons riding in a passenger automobile equipped with seat safety belts or manufactured after July 1, 1966 to wear such belts and to provide penalties. *DISAPPROVED,* because there are certain medical conditions in which the wearing of seat belts is contra-indicated.

A-1483 —To require that each bio-analytical laboratory be under supervision of a person licensed to practice medicine and surgery and certified in clinical pathology or a licensed bio-analytical laboratory director. *DISAPPROVED,* because it is not in the best interest of the public. Many physicians practicing pathology are certified in anatomical pathology, but not clinical pathology although they have extensive training in that field. Many hospital laboratories are supervised by well-qualified physicians who are not certified specialists in clinical pathology. Therefore, if this bill is enacted it will create a crisis situation in many New Jersey hospitals that are providing admirable services to the community.

A-1488 —To permit the Bureau of Children's Services, any physician, any superintendent or medical supervisor, or a medical facility having as one of its objects the prevention of cruelty to children to hold a child in protective custody without court order for 48 hours or until the next court session. *APPROVED*

A-1490 —To provide that facilities and programs for handicapped children shall be chosen by the Board of Education after consultation with the county child study team and the parents or guardians of the child. *APPROVED*

A-1497 —To prohibit practitioners from dispensing methadone without approval of the Commissioner of Health after first informing him of the name of the individual to be treated and amount of methadone to be dispensed. *ACTION DEFERRED,* pending further information from the Committee on Drug Abuse.

A-1504 —To provide that persons subject to convulsive
S-1106 seizures who have not experienced such seizures for a period of one year shall not be denied driving privileges. *DISAPPROVED,* because under existing law that decision rests with the discretion of the Director and that discretion can be tested in the courts.

A-1506 —To prohibit spraying of pesticides harmful to human life on any farm when laborers are in the fields. *APPROVED*

A-1509 —To exempt employees of a humane society from prohibition of the Controlled Dangerous Substances Act. *APPROVED*

A-1510 —To prohibit spraying of pesticides if there are persons in the area or if there is a risk to an adjacent area. *DISAPPROVED,* because it would impose extreme restrictions, which for all practical purposes would make the spraying of pesticides impossible with consequent disadvantage to the public welfare.

A-1513 —To require supermarkets to provide public toilet facilities. *NO ACTION*

A-1516 —To require adult attendants on school buses transporting handicapped children. *NO ACTION*

A-1525 —To prohibit the operation of motor vehicles manufactured after January 1, 1974 unless they have seat belts for all seating positions and shoulder belts for two front seats. *DISAPPROVED,* because there are certain medical conditions in which the wearing of seat belts is contra-indicated.

A-1572 —To provide that a license may be suspended for any person prescribing or dispensing controlled dangerous substances in an indiscriminate manner or where the licensee reasonably knows that the substances previously prescribed or dispensed were used for illicit consumption or distribution. *APPROVED*

A-1574 —To provide that it shall be unlawful to manufacture or offer for sale any glazed ceramic tableware which releases lead in excess of 7 parts per million or cadmium in excess of 0.5 parts per million. *APPROVED*

A-1578 —To permit the Commissioner of Health to grant a waiver of the requirements of examination and a public health degree for a health officer's license for persons who meet certain requirements. *DISAPPROVED,* because it would reduce the present statutory qualifications, with hazard to the public interest.

A-1579 —To provide for medical examinations of school pupils who may be under the influence of drugs by either the medical inspector or any other licensed physician. *APPROVED*

A-1581 —To provide that the prohibitory provisions of the act concerning the practice of medicine shall not apply to the practice of acupuncture by an unlicensed person provided the practice is carried on in a medical school and the primary purpose is scientific investigation. *APPROVED*

A-1590 —To require all motor vehicles regularly used to transport three or more children to and from school to display a sign on the rear of the vehicle stating "Caution-Vehicle Transporting Children." *DISAPPROVED,* because it is impractical of enforcement.

A-1591 —To provide for the licensing of residential child care facilities. *NO ACTION*

A-1601 —To provide that every motor vehicle under the jurisdiction of a Board of Education to transport pupils to and from school shall display a sign calling upon motorists to come to a full stop while the school vehicle is taking on or discharging pupil-passengers. *APPROVED*

A-1609 —To provide for a medical examination of school pupils who may be under the influence of drugs by any licensed physician when the parents or guardian consent. *DISAPPROVED*, because this measure would delay the process of immediate examination.

A-1614 —To permit municipalities to license and regulate health studios, spas, gymnasiums, and any other public facility used for instruction, training or assistance in physical culture, body-building, exercising, reducing, figure development, or any other physical skill. *NO ACTION*

A-1629 —To provide that any correctional institution officer, who suspects any inmate is using any controlled dangerous substance, shall report his findings to the medical officer and the inmate shall thereupon submit to any and all valid examinations. *APPROVED*

A-1630 —To provide that the Department of Environmental Protection shall promulgate, within 6 months after the effective date of this Act, regulations concerning the maintenance of detailed operational records, monitoring and control of dangerous gases, prevention of pollution by seepage, and special treatment of hazardous wastes under "The Solid Waste Control and Landfill Reclamation Act. *APPROVED*

A-1635 —To appropriate $207,313 to the Division of Health Care Facilities to carry out the purposes of the Health Care Facilities Planning Act. *NO ACTION*

A-1637 —To provide that it shall be the duty of the Board of Education to arrange that any pupil suspended or expelled from a public school for more than 7 days shall be examined to determine if he shall be classified as mentally retarded, communication handicapped, neurologically or perceptually impaired, emotionally disturbed, socially maladjusted, multiple handicapped, or as having any other learning disability, and that upon the accomplishment of such determination to provide suitable educational facilities for such pupil. *APPROVED*

A-1644 —To provide that no court may order the release of a person on his own recognizance if charged with the offense of treason, murder, kidnapping, manslaughter, armed robbery, rape or sodomy, or if the alleged victim is under 16 and the person is charged with offenses of carnal abuse, lewdness, impairing morals of a minor or assault with intent to commit rape, carnal abuse or sodomy. *NO ACTION*

A-2004 —To authorize the Department of Health to establish emergency mobile medical care pilot programs. *APPROVED*

A-2013 —To permit the State Department of Health and Local Boards of Health to provide at public expense for the immunization of pupils from diseases which are required to be immunized against under the State Sanitary Code. *APPROVED*

A-2014 —To provide 75 per cent, in place of 50 per cent, State aid for the education of handicapped children. *NO ACTION*

A-2017 —To require persons using methadone, on a drug rehabilitation program, to surrender their driver's license to the Director of Motor Vehicles. *DISAPPROVED*, because it would inexcusably stigmatize the individual being rehabilitated and would discourage recourse to the methadone rehabilitation program.

A-2020 —To permit applicants for examinations to practice medicine and surgery to declare citizenship intent in an affidavit submitted to the Board. *APPROVED*

A-2030 —To provide that the owner of any dog shall be liable for personal injuries caused to a person. *NO ACTION*

A-2048 —To repeal Sections 3, 4, and 5 of P.L. 1952, Chapter 102 of the Prevention of Chronic Illness Act in order to complete reorganization of the Department of Health. *NO ACTION*

A-2052 —To provide that no person, otherwise eligible under the Medical Assistance and Health Services Act, shall be denied eligibility for such benefits solely on the basis of the increased social security benefits effective September 1, 1972. *APPROVED*

A-2067 —To provide for reimbursement of licensed chiropractors for services under the act concerning medical service corporations. *ACTIVE OPPOSITION*, because the services which chiropractors are licensed to provide are not among the services covered by medical service corporations. They are not licensed or recognized as physicians or surgeons and are not qualified—or licensed—to supply medical and/or surgical services for injuries and/or disease conditions.

A-2068 —To provide for reimbursement of licensed chiropractors for services under the act concerning health insurance other than group and blanket insurance. *ACTIVE OPPOSITION*, (See A-2067)

A-2069 —To provide for reimbursement of licensed chiropractors for services under the act concerning group health insurance. *ACTIVE OPPOSITION*, (See A-2067)

A-2071 —To remove the requirement that a person must be a citizen of the United States to receive a license to practice medicine or surgery in this State. *DISAPPROVED*, because the present mechanism of the Declaration of Intent to assume citizenship is adequate to open to foreign physicians the avenue to licensure.

A-2091 —To provide that information in the central registry of the Bureau of Children's Services shall be made available to social caseworkers, probation officers, and members of law enforcement agencies determined to have a professional interest in the control of child abuse. *ACTION DEFERRED,* pending further information from the Committee on Child Health.

A-2104 —To provide for a summer intern program in water pollution control in the Department of Environmental Protection. *NO ACTION*

A-2121 —To establish a "Contracts for Health Studio Services Act" to provide for certain requirements, limitations and prohibitions concerning such contracts; to require health studios to file bonds with the Director of Consumer Affairs; and to provide for recovery of damages upon, and a penalty for, violations. *NO ACTION*

A-2123 —To provide that special need to intercept wire communications shall include a showing that the licensed physician, attorney at law, or practicing clergyman is personally engaging or was engaged over a period of time as part of a continuing criminal activity. *NO ACTION*

A-2129 —To provide that persons convicted of distributing controlled dangerous substances to persons under 18 years of age or convicted of a second offense shall not have their sentences suspended nor be placed on probation. *NO ACTION*

A-2136 —To provide that food shall be deemed misbranded unless it bears a label indicating the nutritive value of the food. *NO ACTION*

A-2152 —To provide that the use of terms "cut-rate," "discount," "bargain," or similar connotation in connection with prices for prescription drugs and narcotics, or fees, or for services relating thereto shall constitute grossly unprofessional conduct under the act concerning the professional conduct and practice of pharmacists. *NO ACTION*

A-2173 —To grant immunity from civil liability to hospitals, clinics, physicians, surgeons, resident nurses, or residents or interns on the staff of a hospital or clinic performing tests and taking breath or blood samples at the request of law enforcement officers. *APPROVED*

House referred back to Council on Legislation for reconsideration the following bills: S-852, S-1041, S-1054, and A-836.

Filed (page Tr 132)

Supplemental Report

Of the bills reported to the House in the 1973 Annual Report of the Council on Legislation, the following have since been signed into law:

A-1442 —To permit the Department of Health to provide appropriate laboratory services for the diagnosis of sexually transmitted diseases, to provide appropriate treatment and to promulgate fees therefor. *DISAPPROVED,* because the imposition by the Department of Health of fees for these services would be inimical to the public health and welfare, especially in view of the fact that in New Jersey we are now in the midst of a venereal disease epidemic. *LAW c. 74 ('73)*

A-1635 —To appropriate $207,313 to the Division of Health Care Facilities to carry out the purposes of the Health Care Facilities Planning Act. *NO ACTION* LAW c. 77 ('73)

Current State Legislation

The following list presents the official position of The Medical Society of New Jersey regarding additional bills currently in the Legislature. Those measures thus marked (*) are identical with bills of last year—or preceding years—and the Society's official position concerning them is the same.

At its meeting on April 15, the Board of Trustees considered and acted upon these recommendations from the Council's meeting of April 12. The Council therefore offers this Supplemental Report covering items dealt with since the compilation of its annual report.

S-2078 —To remove exclusion of agricultural pursuits from requirements for posting State child labor abstracts; to limit farm employment of 14 and 15 year old children to periods not interfering with school and health; to prohibit farm employment of 12 and 13 year old children; to prohibit employment of minors, ages 14 and 15, near power driven machinery and to set maximum hours of farm work for children as 8 hours. *APPROVED*

S-2101 —To provide for supervision of projects for prevention of blindness by the Commission for the Blind and to provide that funds shall be made available on a project basis for programs conducted by the Department of Health and organized health services groups. *NO ACTION*

S-2109 —To include central services facilities operated by, rather than serving, institutions within definition of "health care facility" in the

Health Care Facilities Planning Act. *APPROVED*

S-2121 —To provide that with regard to an abortion or the performance of a sterilization procedure, written consent must be obtained from the spouse, in the case of a married minor, or from the parent or legal guardian in the case of an unmarried minor. *TABLED*

S-2122 —To provide that the act concerning the practice of medicine and surgery shall not apply to the performance of any act at the direction and supervision of a licensed physician by a person working under a job description approved by the Board of Medical Examiners and possessing qualifications established by the Board. *APPROVED*

S-2129 —To provide that no debris shall be placed into any stream, upon any stream bank or into the Atlantic Ocean or any of its bays or kills and to provide penalties. *APPROVED*

S-2135 —To provide that any hospital with an accredited coronary care unit may apply to the State Department of Health for approval to conduct a pilot program in emergency mobile intensive care procedures and rescue acts in cooperation with voluntary health agencies and to appropriate $200,000. *APPROVED*

S-2148 —To establish a Health Maintenance Organizations Act, to provide alternatives for health care delivery, to provide for establishment and certification of health maintenance organizations and to establish the duties and responsibilities of the Commissioners of Health and Insurance in supervising these organizations. *APPROVED*

S-2158 —To revise the statutory law with respect to consent by minors to performance of hospital, medical or surgical procedures or treatment. *TABLED*

S-2194 —To require the State Department of Health to test all newborn infants for phenylketonuria. *ACTION DEFERRED*, pending further information from the New Jersey Chapter of the American Academy of Pediatrics.

S-2200 —To provide that fetal weight of 500 or more grams shall require a death certificate and a burial or removal permit if the gestational age is questionable. *APPROVED*

S-2201 —To provide that the Department of Health shall prepare lists of family planning clinics in the State together with birth control information pamphlets for distribution by marriage licensing officers. *APPROVED*

S-2213 —To provide that no person shall be required to perform or assist in an abortion or sterilization and no hospital or other health care facility shall be required to provide such services or procedures. *APPROVED*

S-2214 —To define and include "abortion service facility" under the law concerning licensing and regulation of health care facilities. *APPROVED*

S-2226 —To establish in the Department of Health a program for the identification, eradication, and treatment of Beta Hemolytic Streptococcus infection. *APPROVED*

S-2230 —To require health care facilities in collaboration with the municipal disaster control director and local fire officials to formulate fire and disaster operation plans and to conduct drills at least monthly at irregular intervals. *APPROVED*

SCR-2022—To memorialize the Congress of the United States to amend the Constitution of the United States to effectuate protection of unborn humans. *NO ACTION*

A-2091 —To provide that information in the central registry of the Bureau of Children's Services shall be made available to social caseworkers, probation officers, and members of law enforcement agencies determined to have a professional interest in the control of child abuse. *APPROVED*

A-2201 —To provide that a person who shall destroy an animal except by a method of euthanasia generally accepted by the veterinary medical profession shall be guilty of a misdemeanor. *APPROVED*

A-2240 —To provide that any hospital having an accredited coronary care unit may apply to the Department of Health for approval to conduct a pilot program in emergency mobile intensive care procedures and rescue acts in cooperation with voluntary health agencies and to appropriate $200,000. *APPROVED*

A-2241 —To create a State Board of Acupuncture in the Division of Consumer Affairs to regulate the practice of acupuncture and to require licensing. *DISAPPROVED, WITH ACTIVE OPPOSITION IF THE BILL MOVES,* because this bill would license individuals to practice acupuncture, even though the scientific validity of acupuncture has not been satisfactorily established. Moreover, it would jeopardize the health and welfare of the public by failing to require that licensed acupuncturists meet all the qualifications imposed by the State upon individuals who practice medicine, since obviously acupuncture would fall under the definition of medical practice as set forth in R.S. 45:9-1 et seq.

A-2256 —To provide that boards of education shall identify children between the ages of 4 and 21, in place of 5 and 20, in public schools who cannot be properly accommodated through school facilities usually provided because of handicaps. *APPROVED*

A-2269 —To provide that no licensed chiropractor, not registered to use physiotherapy modalities, shall use such modalities. *APPROVED*

A-2276 —To provide that no hospital or clinic shall be required to provide facilities or services for the performance of an abortion other than for an emergency case. *APPROVED*

A-2277 —To require the certification of diagnostic information for the use of the county court at final hearings on commitment of patients in

mental hospitals where continued care and treatment beyond a 20-day temporary commitment is recommended. *APPROVED*

A-2291 —To delete the word "willfully" in R.S. 9:6-1 concerning the abandonment, abuse, cruelty and neglect of children. *APPROVED*

A-2294 —To authorize the Department of Health to establish programs of rehabilitation for drug dependent persons, to provide facilities and to provide for licensing operators of such facilities. *DISAPPROVED*, because the legislation is unnecessary in view of the fact that the requested authority already inheres in the Department of Health and is being exercised through the Department's Division of Drug Abuse Control.

A-2315 —To require the Board of Pharmacy to compile a list of the 100 most used prescription drugs and to require drugstores to post the prices for such drugs. *APPROVED*

A-2317 —To provide that the failure of a doctor, dentist or other person in licensed medical practice to disclose to a patient the cost of services paid to laboratories for tests shall be a misdemeanor. *APPROVED*

A-2321 —To establish the "New Jersey Poison Prevention Packaging Act" authorizing the Commissioner of Health to regulate the packaging of household substances dangerous to the health of children. *APPROVED*

A-2322 —To provide the Commissioner of Health the powers to regulate the labeling of hazardous substances and of hazardous toys; to provide the Commissioner power to remove from commerce hazardous substances and toys that are inadequately labeled or misbranded. *APPROVED*

A-2327 —To require continuing education for registered optometrists in order to qualify for renewal certificates. *NO ACTION*

A-2329 —To provide that hospital patients shall be entitled to receive, upon request, a free copy of the total bill for services rendered. *APPROVED*

A-2349 —To require that a child may be placed for adoption through a person, firm, corporation, association or agency approved by law and not by the parent. *APPROVED*

A-2361 —To require drivers of and passengers in motor vehicles equipped with seat belts to properly utilize such restraints and to permit the Director of Motor Vehicles to grant exemptions. *DISAPPROVED*, because it is discriminatory and unfair and would impose upon the public at large restrictions which have not yet been imposed on vehicles of public transportation.

A-2365 —To provide that any child who is afflicted with the disease of sickle cell anemia shall be eligible for the care and treatment provided for crippled children. *APPROVED*

Filed (page Tr 132)



House of Delegates—First Session

Administrative Council

Medical Services

Louis K. Collins, M.D., Chairman, Glassboro

(Reference Committee "F")

The Council is charged with the responsibility of studying and evaluating matters relevant to the maintenance and advancement of the standards and character of medical practice in New Jersey, and the investigation of the economic and social aspects of medical care.

Conference on the Efficient Use of Health Care Services

Dr. David Brewer, a member of the Council, attended this Conference sponsored by the AMA as MSNJ's representative. Dr. Brewer's detailed report concerning the establishment of similar workshops in New Jersey was received by the Council with commendation and referred to the Foundation for possible implementation as being more within its purview.

Uniform Medical Procedural Terminology and Code Project

The Society was contacted by the Bureau of Health Services and Mental Health Administration of HEW, and requested to participate in a project to test a proposed uniform medical procedural terminology system for medical visits and therapeutic procedures for feasibility, acceptability, and possible fee ramifications under Medicare and Medicaid. This matter was referred by the Executive Committee to the Council.

The Council met with the representatives of HEW and the fiscal intermediary. The proposal placed before the Council was that a random selection of 200 physicians in various specialties and diverse geographical locations would be asked to use a modified 1490 SSA Form during a 90-day period.

The physicians were to use the terminology proposed by HEW and were to bill in any amount they deemed advisable for the service. Payments of course were to be within presently controlling formulas.

We felt that the statistical information would be of value but questioned the methodology and suggested that an in-depth personal interview of randomly selected physicians would provide more accurate and meaningful data. The Bureau of Health Services and Mental Health Administration agreed to this change in format and we are currently in the process of expediting the project.

Proposed Changes in Policy on Injectables Including Immunizations and the Removal of the Requirements of Prior Authorization for Injectable Drugs

The Medicaid Negotiating Committee reviewed a memorandum from the Chief of the Bureau of Professional and Technical Services to the Medical Director of the Division of Medical Assistance and Health Services. It pertained to changes in the injectable policy presently adhered to by the Division. The Council recommended to the Board of Trustees that the proposal be approved and the Division so notified. At the same time it is to be clearly understood that we will continue to press for payment for other injectables and prosthetic devices that are supplied by physicians. The Board concurred and our approval of the following exhibit has been forwarded to the Division.

Exhibit

Date December 18, 1972

To: J. Charles Breme, M.D., Medical Director
Division of Medical Assistance and Health Services

From: I. Fulton Erlichman, M.D., Chief
Bureau of Professional and Technical Services

Subject: PROPOSED CHANGES IN POLICY ON

INJECTABLES INCLUDING IMMUNIZATIONS AND THE REMOVAL OF THE REQUIREMENTS OF PRIOR AUTHORIZATION FOR INJECTABLE DRUGS

The following is to replace the present section 202.1 in the physicians' manual and will result in the omission of the present section 220 F.3 also in the physicians' manual. Other concerned manuals will require adjustment, where indicated.

202.1 *Injections and Drugs Dispensed by the Physician*

A. Oral Route:

This class of medications is not reimbursable when dispensed by the physician.

B. Intradermal, subcutaneous or intramuscular injections given in an office or home setting:

Reimbursement will be made on a flat fee basis which will be *all inclusive* for the cost of the service and the drug.

Exception:

(1) No reimbursement will be made for vitamin or liver and iron injections except in laboratory-proven deficiency states. (Submit evidence.) Example: pernicious anemia proved by a positive Schilling test.

(2) No reimbursement will be made for hormones except in cancer therapy or hormones of adrenocortical or pituitary origin.

(3) No reimbursement will be made for injections given for a primary diagnosis of obesity.

(4) No reimbursement will be made for placebos or any injections containing amphetamines.

(5) No reimbursement will be made for more than one injection per visit and *the drug used must be consistent with the diagnosis.*

C. Intravenous or intra-arterial injections in the office or home setting:

Reimbursement will be made only when performed by a physician.

D. Injectable prescription drugs are not reimbursable.

Exception:

(1) Long-term care facilities.

(2) Intravenous or intra-arterial anti-neoplastic drugs.

(3) Drugs to be given to a patient by other than a physician or his employee.

E. Billing procedure:

Code number XXXX (injection—intradermal, subcutaneous, intramuscular) or code number XXX I (injection—intravenous or antra-arterial) whichever is appropriate must be inserted on physician claim form MC-8 as a *separate item under 12 D., followed by name, dose of drug, and the diagnosis.*

These are the salient features of several of the more important elements we processed this year. I wish to thank the members of the Council for their cooperation. My special thanks go to Dr. Karl Franzoni who as vice-chairman has guided the efforts of the Council during my recent illness.

Filed (page Tr 133)



President D'Elia presents commerative plaque from the Board of Trustees to retiring Executive Director, Richard I. Nevin

Special Committee to Council on Medical Services

Occupational Health, Workmen's Compensation, and Rehabilitation

Delma W. Caldwell, M.D., Chairman, Linden

(Reference Committee "F")

The Committee on Occupational Health, Workmen's Compensation, and Rehabilitation had various exchanges throughout the year relative to: (1) OSHA requirements, and (2) New Jersey State Rehabilitation Commission's efforts to aid industry in rehabilitation of disabled employees.

At the special request of Dr. Robert S. Albahary, we met with the Special Committee on Alcoholism on February 28th of this year at the State Society headquarters. It was felt that these two committees could proceed to work together on the problem of alcoholism. It was stated that the major thrust of the combined committees would be (1) to work toward education of the physicians in the problem of alcoholism, (2) the possibility of including the treatment of alcoholism in the curriculum of medical schools, and (3) creating a referral system for after-care.

The Committee expects to continue these projects during the next administrative year.

Filed (page Tr 133)



Incoming President and Mrs. Boylan, their family and guests

Administrative Council

Mental Health

Robert S. Garber, M.D., Chairman, Belle Mead

(Reference Committee "F")

The primary concern of our Council continues to be the state of affairs regarding the Division of Mental Health of the State of New Jersey.

We have been totally unsuccessful in our efforts to achieve establishment of a separate Department of Mental Health by removing it from the Department of Institutions and Agencies.

Equally disappointing is the fact that another year has gone by without the guidance of a psychiatrist as the Director of Mental Health. This is particularly frustrating to the Chairman of the Council since he has served as Chairman of a state-wide Search Committee and all efforts to find qualified candidates for the post on the terms offered have been fruitless.

See notation (page Tr 133)

The Council continues to feel that, unless the full weight of the entire Medical Society (including its Board of Trustees) is placed solidly behind a drive to achieve these two objectives, little can be expected of the future.

A carry-over from the previous year has been our disagreement with the New Jersey State Department of Health's interpretation of the legislation, which provided the "Practitioner's Report of Controlled Dangerous Substance Abuser." We still contend that the report goes beyond the original intent of the legislation.

However, after several meetings involving heated discussion of the topic, we remain temporarily restrained while awaiting developments. We encourage the reporting of any instances wherein physicians can point to a break in confidentiality *or* the prevention of needed emergency treatment because of the patient's fear of the reporting procedure.

Special Committe on Alcoholism

The Special Committee on Alcoholism has been reactivated with a new Chairman and new members. Consequently, this year has been primarily utilized in establishing attainable goals in the realm of physician education and establishing contact with industrial medical programs.

Special Committee on Drug Abuse

Under its new Chairman, the Committee continues to watchdog the methods and procedures used by the Division of Narcotics and Drug Abuse Control. The Committee will prepare a statement, for possible publication in *The Journal*, regarding the safeguards and precautions installed in the registry to preserve confidentiality.

Special Committee on Emotional Disorders of Childhood and Adolescence

This Committee has been busily involved in the preparation of a Directory of available facilities for the mentally ill or emotionally disturbed child.

Special Committee on Mental Retardation

The Chairman has been fraught with discouragement and disappointment due to a totally apathetic committee (save one member). He is hopeful of establishing an adequately equipped and staffed diagnostic center relevant to genetic defects and inborn errors in metabolism within the confines of our State. To this end the Committee has been in communication with the Commissioner of the De-

partment of Institutions and Agencies and with both New Jersey medical schools.

Special Committee on Neurological and Related Disorders

This Committee has been trying to identify rehabilitation facilities available to spinal-cord-injured patients and to stroke patients.

At our concluding meeting this year, we advised the Board of Trustees of our willingness to provide liaison between our Council and the Council on Legislation in the area of mental health.

Filed with notation (page Tr 133)

Special Committees to Council on Mental Health

Alcoholism

Robert S. Albahary, M.D., Chairman, New Brunswick

(Reference Committee "F")

The Committee met regularly at scheduled times and with good attendance.

1. One of the early observations of the Committee was that the administration and deliverance of services for Alcoholics in the State of New Jersey was in a rather confused state. There are many known and unknown agencies, "all funded with the monies coming from the Federal Government and engaging in the variety of programs without any coordination."

A good example is in Middlesex County where there are four different programs in existence operating independently of each other and without any coordination (National Council on Alcoholism, New Jersey Vocational Rehabilitation, O.E.O., and Raritan Bay Regional Health Center).

The Committee believes that The Medical Society of New Jersey should be influential in creating a coordinating agency which will regulate and oversee the multitude of programs for alcoholics which at the present constitute a tremendous waste of manpower, talent and much-needed money.

2. The Committee has considered and examined the proposed Uniform Alcoholism and Intoxication Treatment Act.

The Act has been drafted by the Council of Commissioners of Uniform State Laws, with the prime purpose of providing legislation which would be uniform throughout the United States and could be adopted by each State rather than having Congress enact overreaching Federal legislation. The recommendation of the National Conference is that this Act be enacted in all of the states of the Republic.

The State of New Jersey had a bill very similar to this introduced by Assemblyman Dennis in April 1972 and another version introduced later in the year.

The Committee finds these two acts essentially similar and recommends that the Medical Society come out in favor of the Dennis Bill with minor modifications, (which will be furnished upon request).

The Committee also recommends that the Medical Society write to the Attorney General's office requesting their position in reference to this Uniform Act and requesting specifically that they confer with us to consider

what modifications of the Dennis Bill might be deemed advisable.

3. The Committee has been examining the extent of the alcoholic problem in industry and in this regard has met with the Committee on Occupational Health, Workmen's Compensation, and Rehabilitation. The problems are rather vast and not easily solvable, but will be considered in further sessions by the Special Committee on Alcoholism.

The Committee suggests that in the future these two committees operate jointly and with common effort. This proposed effort has been already accepted by members of both committees.

Filed (page Tr 133)

Drug Abuse

Hans W. Freymuth, Chairman, Trenton
(Reference Committee "F")

While the drug scene as a whole seems to have remained as active as ever, certain changes have been occurring.

An increasing number of observers seem to agree that heroin addiction has been leveling off, or perhaps even slightly decreasing. The following reasons are mentioned:

1) Efforts by law enforcement to control heroin traffic have become increasingly successful with the result that heroin has become less available and the quality of street heroin available on the blackmarket has been decreasing.

2) There appears to be an increasing awareness among young people that heroin addiction is malignant and represents a condition from which it seems extremely difficult, if not impossible, to escape.

While methadone has proved quite successful in treating hard core heroin addicts, street methadone addiction has been on the increase.

Recent steps taken by Federal agencies include removal of methadone from commercial pharmacies, limiting its use only to approved methadone maintenance programs. Whether this step will lead to a reduction of methadone traffic remains to be seen.

Hand-in-hand with some reduction in the use and popularity of heroin, seems to have occurred an increase in the use of other drugs. The use of barbiturates seems to be on the increase. Among the non-barbiturates, metaqualone (Quaalude®) use appears to be increasing rapidly and is said to have assumed endemic proportions in certain parts of the country. The stimulants, mostly represented by methamphetamines and their derivatives known as "speed," have remained popular but young people seem to have become more sophisticated in their use. Methamphetamine intoxication is not seen as frequently as some time ago.

The hallucinogens seem also to have lost some popularity.

The legalization of marijuana, the use of which has continued to be widespread among young people, has been under serious consideration and we may see at least partial legalization of marijuana in the near future.

From a medical standpoint this is probably undesirable and might very well open a Pandora's box, forcing us to legalize any number

of other mind-bending substances, legalization being based on similar rationalizations as applied to marijuana: that the drug is relatively harmless and its moderate use does not seem to have major harmful consequences.

Finally, there seems to be a trend toward increasing use of alcohol among young people.

On the state level, the State Department of Health has continued to run a network of treatment facilities, mostly providing treatment of hard core heroin addicts with methadone maintenance. While this program has been quite successful in rehabilitating many of these addicts (according to statistics approximately 70 per cent) termination of methadone maintenance has been, so far, disappointing and unsuccessful in the majority of cases. Better procedures for termination of methadone maintenance must be found unless we want to resign ourselves to seeing many of these people on methadone maintenance for perhaps the better part of their life.

Reporting of addicts to a State Registry, maintained by the State Department of Health, has become State law. The registry has not been popular with physicians and many objections have been raised, mostly based on the assumption that the registry does not provide enough professional confidentiality. However, there is little practical evidence that reporting to the registry had led to detrimental consequences for addicts. On the other hand, the registry has started to provide quite valuable statistical information.

State certification of all drug treatment facilities has also become a requirement, allowing the Department of Health to have some control of physical facilities as well as treatment procedures.

While the practicing physician's role in treatment of drug addicts will probably remain limited, particularly after the withdrawal of methadone from the pharmacies, physicians should develop an acute awareness of the potential dangers connected with the prescription and use of certain drugs. This is particularly true in treating young people who often appear much more addiction-prone than patients belonging to the older age group. Great caution should be used in prescribing amphetamines for weight reduction or hypnotics for insomnia. Non-barbiturate hypnotics seem to be often not less dangerous than the barbiturates.

Of the group of so-called tranquilizers, the addictive propensities of meprobamates, as well as drugs like Librium® and Valium®, require careful consideration. Prescription of large amounts of any of these drugs should be avoided.

While physicians probably in many instances will not have the time or inclination to get involved in the treatment of drug addicts, they should be aware of the treatment facilities available in their community and neighborhood for referral purposes.

Finally, practicing physicians might be in a position to help improve acceptance of drug addicts in emergency wards as well as inpatient facilities in our general hospitals. There has been considerable resistance against accepting or treating this type of patient, sometimes with catastrophic results.

Physicians active in community life can be helpful in providing information about drug abuse and should assist with prevention efforts.

Filed (page Tr 133)



Fellow and Mrs. Louis K. Collins

Emotional Disorders of Childhood and Adolescence

Eugene V. Resnick, M.D., Chairman, Paramus

(Reference Committee "F")

Brought to the Committee's attention this year were difficulties physicians and other professionals were having in referring children and adolescents, who required service for their mental health problems, to appropriate practitioners or facilities. In some instances, this seemed to result from the lack of such practitioners and facilities, but in many other instances the practitioners or facilities were available but were not known to the referring professional, or the nature of their services was not known.

In an attempt to help remedy this situation, the Committee proposed publication, under Medical Society sponsorship, of a directory of mental health services, covering facilities available to New Jersey residents. The directory would cover broadly all types of mental health facilities and would give relatively detailed information about each facility listed, including information about its staff composition, range of services provided, geographical area served, fee schedules, and application procedures. Outpatient facilities which consisted essentially of an individual professional or group of professionals in private practice would not be included in the directory, since an adequate listing of private physicians already exists in the MSNJ Membership Directory.

The Committee has worked to implement its proposal and has made much progress in developing mechanisms to collect the necessary data and to have it published and distributed, all at nominal expense to the Medical Society.

It is expected that the directory will be a cooperative venture with the New Jersey Association for Mental Health.

Filed (page Tr 134)

Mental Retardation

Miles E. Drake, M.D., Chairman, Vineland

(Reference Committee "F")

The Committee on Mental Retardation met three times during the year. Discussion of a diagnostic center was again a focal point of the meetings.

The Chairman met with Mr. Bernard L. White, Deputy Director, Division of Mental Retardation, on February 28, 1973, and a general discussion centered about a diagnostic center. A discussion of the Mental Retardation Center in Newton ensued. This was shown to be not a diagnostic or treatment center, but a day training center.

It is our conviction that the Committee has established some concern for a center and we feel that next year's Committee must press for this vital facility and keep the issue before Dr. Maurice Kott and Mr. B. L. White.

Filed (page Tr 134)

Neurological and Related Disorders

J. Lloyd Morrow, M.D., Chairman, Passaic

(Reference Committee "F")

This year the Committee considered the identification, evaluation, and disposition of stroke. We recognize that there are two phases of stroke, the acute stage and the rehabilitative stage. Recent studies reveal that there is a 70 to 80 per cent recovery success if the rehabilitative process is initiated as soon as possible.

There are very few comprehensive facilities available in New Jersey, and we are working on a study as to how to meet these needs.

The mental health aspects of stroke are those of any catastrophic physical disorder. Signs of acute and chronic brain syndromes with or without psychosis require the perceptive management and expertise of the physician. Many patients can be treated at home or in nursing homes. Psychiatric consultation and advice should be more widely employed.

In view of increasing automobile, motorcycle, and swimming pool accidents we are investigating rehabilitative services available to patients with spinal cord injuries and hope to present a definitive report in this regard to the next House of Delegates.

Filed (page Tr 134)



MSNJ Staff—1973 Annual Meeting



Ovation honoring Mr. Nevin on the occasion of his being named Executive Director Emeritus by acclimation of the House.

Administrative Council

Public Health

Robert G. Salasin, M.D., Chairman, North Wildwood

(Reference Committee "G")

The Council on Public Health has had an interesting year. Many of the items brought to our attention were initially considered by the special committees to the Council. As a result those matters are not dealt with herein but in the reports of the special committees which follow.

MSNJ's Comprehensive Planning Group

The Council took the position that the Society should establish its own comprehensive planning committee to reflect the opinion and attitudes of its members regarding the development and regionalization of sophisticated health services since State and Federal agencies have not consulted practicing physicians. The Board of Trustees saw the need for input in this area and established a committee to assist existing governmental health planning agencies. The Board pointed out that, legally, planning is the responsibility of State and Federal agencies by virtue of Public Law 89-749 as amended, and noted that the Society has had input and representation at the State and Regional levels. Additionally, adequate planning organization along with certification of need would probably require a budget in excess of a million dollars.

Screening of Hearing

At the request of the Subcommittee on Conservation of Vision, Hearing, and Speech and the Council on Public Health, the Board of Trustees requested the Council on Legislation to cooperate with the State Department of Education in the introduction and advancement of legislation that will provide adequate and standardized methods of screening of hearing in New Jersey schools.

Rubella

The Council reaffirmed its earlier position that rubella immunization should be discretionary and not mandatory. We also support the concept of transferring authority in regard to immunizations of all types from the local school boards to the Public Health Council of the State Department of Health.

Blood Transfusions

The Council was notified by the Department of Health, that there appears to be an overuse of blood in our hospitals. We urged the Board of Trustees to establish a subcommittee and the Council on Medical Services to evaluate this seemingly difficult area. The Board consensus was that this item should be referred to the New Jersey Foundation for Health Care Evaluation and the New Jersey Blood Bank Association, as it is more properly within their purview.

Filed (page Tr 137)



Incoming President and Mrs. Boylan

Special Committees to Council on Public Health

Cancer Control

Roy T. Forsberg, M.D., Chairman, Elizabeth

(Referenee Committee "G")

The Committee on Cancer Control met once during this year. The reason for only one such meeting is that the chairman could find little reason for congregating talented M.D.'s when scope and function are never clearly identified and its function seemed very unimportant.

Because of this, and because of our very strong feeling that the problem of cancer should be assigned to a role of major concern, we offer the following.

Recommendations

1. That the Medical Society of New Jersey allot some portion of its annual meeting to the problem of Oncology; that the Committee on Cancer Control prepare and be responsible for the presentation to all New Jersey Medical Society members the following: (a) newest advances in cancer and (b) report on statewide statistics.

Approved (page Tr 137)

2. That The Medical Society of New Jersey become actively involved in the regionalization of a cancer treatment program throughout New Jersey.

Approved (page Tr 137)
Filed (page Tr 137)

Child Health

William J. Farley, M.D., Chairman, Brielle

(Referenee Committee "G")

Pediatric Nurse Associate

Upon request of the Board of Trustees a statement was submitted approving the concept of the expanding role of the properly trained nurse assisting in the health care of children, under the supervision of a physician. Appropriate areas of care would be well-child supervision, counseling in child rearing practices, and treatment of minor illnesses.

Child Abuse Program

The "Guide to the Medical Management of Child Abuse," organized by the Committee, was sent to all hospital emergency rooms in the State, and a preliminary survey suggested that it is being used. The small brochure sent to all physicians in the State alerting them to the problem evoked a satisfactory response and request for the Guide from many private physicians.

The Committee has been in contact with organizations and agencies working on this problem especially in regard to programs for group counseling of the offenders. Further legislation is being studied.

Hospital Perinatal Study Conferences

The Committee has received encouraging reports and response to this program. A statewide statistical review of individual hospital experiences has not been found feasible or

advisable. The most productive aspect has been the stimulation of more adequate evaluation and case study in each hospital. A network with close lines of communication with designated conference chairmen will be established. It is anticipated that this program can be utilized to disseminate information on newer aspects of perinatal medicine.

Sickle Cell Anemia

The Committee responded to a directive from the Council on Public Health concerning screening for sickle cell disease. It was judged that mass screening at any age and especially of school children is inadvisable. It is discriminatory and should be on a voluntary basis or part of a periodic health evaluation that will include adequate counseling. Detection may be warranted during routine premarital or prenatal blood examination. Screening for a wide-range of genetic problems and hemoglobinopathies similar to the present PKU Test program in the newborn period deserves study.

School Health Services

The State Department of Education was contacted concerning present school medical forms, and their utilization.

The Committee questioned the productivity of the use of the phono-cardio scan in schools as a routine procedure. It would seem to have no place in a well organized school health program as a substitute for adequate medical participation.

The Medical Society of New Jersey was represented at an organizational meeting on the School Nurse Specialist arranged by the New Jersey State School Nurses' Association.

Filed (page Tr 137)

Conservation of Vision, Hearing, and Speech

Alfonse A. Cinotti, M.D., Chairman, Jersey City
(Reference Committee "G")

1972 Eye Health Screening Program

This year 86 centers participated in the program. There were 12,854 persons screened. Of that number 7,155 negative results were obtained and 5,699 positive results were presented. There were 593 tonometry suspects. Follow-up has established that there were 127 positive glaucomas and 53 suspect glaucomas. The 1973 Eye Health Screening Program will be conducted during the week of October 8, 1973.

At the request of the Committee, the Board of Trustees approved the following recommendations:

1. That the Council on Legislation encourage and assist in the introduction and advancement of legislation that will provide adequate mandatory methods of screening of hearing in New Jersey schools.

2. In regard to Assembly Bill 1397 (having to do with the compulsory reporting of an uncorrectable visual deficiency to the Director of the Division of Motor Vehicles) the Committee recommends: That the Council on Legislation oppose A-1397 and recommend that the New Jersey Division of Motor Vehicles have at periodic intervals, re-examination of licensed motorists, and that those found to have deficient vision be referred for proper eye care.

3. Assembly Bill 1179 regarding the licensing of audiologists was disapproved by the Committee as well as the Society with the viewpoint that the creation of yet another licensed group would not be in the best interests of the patient.

The Booklet, "An Eye Health and Screening Program for Schools" has been updated to include a section on Dyslexia.

Filed (page Tr 137)

Environmental Health

Roslyn Barbash, M.D., Chairman, Teaneck

(Reference Committee "G")

The committee actively attempted to coordinate the facilities of the New Jersey Department of Environmental Protection and the New Jersey State Department of Health to delineate the problems of environmental health in New Jersey and to develop preventive and protective measures for the population so continuously exposed to diverse environmental hazards in this state.

The Department of Environmental Health did assign a member of its staff to help develop a program consistent with the expressed wishes of this Society. Meetings took place with Federal Health representatives, the New Jersey Department of Environmental Protection, the New Jersey Health Department, this Committee, and several physicians (recommended by this Committee) who were interested in taking an active part in this research. To date these efforts have not been productive.

The Committee was represented at the Chicago AMA meeting on Environment and a comprehensive report was made to the Board of Trustees.

Filed (page Tr 137)

Maternal and Infant Welfare

Leopold E. Thron, M.D., Chairman, Paterson

(Reference Committee "G")

The Committee reviewed the statistics on maternal deaths during 1972. There were 22 maternal deaths in New Jersey last year as compared to 49 in 1970 and 38 in 1971. Hopefully, that steadily declining trend will continue. Completed reports were not available in four of the cases since they are still being investigated.

The Committee is preparing appropriately selected cases for publication in *The Journal.*

Abortions

It is evident that guidelines regarding the performance of abortions in New Jersey will be necessary in the wake of the recent United States Supreme Court ruling. The President of The Medical Society of New Jersey is currently meeting with the Commissioner of Health and the Attorney General, in an effort to develop guidelines and appropriate legislation, and the Committee is eagerly awaiting the results of those deliberations.

Maternity Service Record Books

We are in the process of revising the Maternity Service Record Book and hope to send the final copy to the printer in early June. The book is widely accepted both in New Jersey and across the country.

Filed (page Tr 137)

Administrative Council

Public Relations

Howard D. Slobodien, M.D., Chairman, Perth Amboy

(Reference Committee "E")

This past year marked a decided change in the scope and direction of the Council on Public Relations. This change was prompted not only by consideration of referrals from the 1972 House of Delegates, but also by self-initiated interest on the part of the members of the Council on Public Relations, the Board of Trustees, and members of the Administrative Staff. The following items, with the approval of the Board of Trustees and the House of Delegates, were conducted:

1. The crash program on blood procurement was reviewed and information obtained from Martin Goldfield, M.D., Director, Division of Laboratories, Department of Health regarding its effectiveness. The program was changed to a continuing one of increased voluntary donations, without the use of paid advertisements.

2. The following continuing projects were approved:

A) Publication and distribution of:

1. Junior Health Hints to schools and public libraries. Series #3 is under current revision.

2. Membership Newsletter, including the annual compilation and distribution of a bound, indexed set to component societies.

3. Periodic newsletter to cooperating agencies/individuals as required.

B) Preparation and publication of special news releases and publicity as required from time to time, in furtherance of the Society's business, interests, and activities, including:

1. The Annual Eye Health Screening Program
2. The Annual Meeting
3. Child Safety Week
4. Selected official programs and activities

C) Responsibility for the informational center and issuance of press releases at the Annual Meeting.

D) Encouragement of continuance of establishment of orientation programs for new members under the sponsorship of component societies.

E) Encouragement of statewide emergency medical care coverage, particularly with reference to the "Basic Concepts Underlying the Provision of Professional Medical Care" as adopted by the House of Delegates and printed in the "Appendix of Reference Information" of the *Membership Directory*.

F) Encouragement of Future Physicians Clubs in each county with MSNJ serving as a clearing house at State level. A symposium is planned and a physician with wide experience in these efforts (Dr. Kalb of Essex) will be asked to chair the meeting. Questionnaires returned from component societies demonstrate this need.

G. The 1972 Golden Merit Award was bestowed upon 31 members of the Society, 11 of whom accepted the award personally in Atlantic City. This brings the total recipients of the Golden Merit Award since its inception in 1957 to 687. Thus far this year, there are 55 prospective recipients of the Golden Merit Award.

The 17th annual bestowal of the Golden Merit Award will take place, in conjunction with the Society's 207th Annual Meeting, on Sunday, May 13, 1973. It will be presented as part of the General Session. This adjustment of the program of bestowal it is hoped will stimulate greater interest and larger attendance.

H. The Informational Center at the Annual Meeting will again be in operation for the accommodation of representatives of the news media. We were advised by Mr. Edward F. Meara, III, Public Relations Counsel of MSNJ, of the excellent coverage by the press, including AP and UPI, at the 1972 meeting. Our activities in this regard will be intensified this year under Mr. Meara's direction.

3. This year a program of radio broadcasts was instituted. Thirty-second tapes, professionally produced at a cost of approximately $200 per set were supplied to radio stations throughout New Jersey and to selected stations in adjoining states. A subcommittee, consisting of Doctors Howard D. Slobodien, John A. Sakson, and John J. McGuire, has met frequently to discuss policy decisions and other problems concerning news releases and to select and clear materials for taping.

4. A large percentage of the efforts of the Council was expended in considering Resolution 26 from the House of Delegates (May 1972). The pertinent portion of the resolution stated:

RESOLVED, that the House of Delegates empower the Council on Public Relations to conduct a survey, which shall include open hearings in each of the five judicial districts, to ascertain directly from the members their thinking on the subjects of:

a. Formation of a medical union.

b. Implementation of an articulate, aggressive public relations program.

c. The future of JEMPAC.

d. Other pertinent subjects for the benefit of members of The Medical Society of New Jersey . . . and report its findings to a special meeting of the House of Delegates in the Fall of 1972.

Individual members of the Council acted as coordinators and chairmen of the hearings in each of the judicial districts. These hearings were held on successive Wednesday evenings in July and August (1972) at Morris Plains, Paterson, Trenton, Mount Holly, and Vineland. The following percentages of members of the five judicial districts were in attendance.

1st District (Essex, Morris, Union, Warren)	2.4
2nd District (Bergen, Hudson, Passaic, Sussex)	.9
3rd District (Hunterdon, Mercer, Middlesex, Somerset)	1.5
4th District (Burlington, Camden, Monmouth, Ocean)	2.0
5th District (Atlantic, Cape May, Cumberland, Gloucester, Salem)	4.0
Over-all average	2.16

On the basis of information received, survey ballots were mailed in advance of the special meeting of the House of Delegates to 8,226 Society members. Of that number, 2,609 ballots were completed and returned for a percentage return of 31.7.

The mandated Special Session of the House of Delegates was held on Sunday, December 10, 1972, at Notre Dame High School, Trenton, New Jersey. The House received the full report of the hearings and the survey, submitted by the Chairman of the Council on Public Relations. The actions taken at that Special Session are contained in the report of the Board of Trustees.

The Council subsequently considered the action taken by the House of Delegates in regard to expanding the Society's public relations program.

Mr. Meara, Public Relations Counsel, gave it as his opinion that movement into a hastily accelerated program with expenditures of up to $105,000 per annum was not warranted at this time. He preferred—and the Council and the Board of Trustees concurred—to effectuate a gradual development and expansion into a more complete and effective program by the following means:

a. Issuance of general news releases regarding the Society's position on topical medical matters and presenting the Society's positions on various pieces of legislation affecting medicine being considered in the New Jersey Legislature. This program could develop into a minimum of three to four news releases a month.

b. Based on the enthusiastic response of our initial 30-second radio spot announcement on the blood shortage, this phase of the Society's program will be continued. Mr. Meara noted that Radio Station KYW (Philadelphia) informed the Society that they contributed 22 public service announcements for our blood program that were worth $1,012, if charges were levied.

Sub-Committee on Media Releases should be actively involved in creating a continuous series of significant concise health hints for distribution to radio broadcasting stations, to be used as spot announcements.

c. Formal press conferences should be held in connection with the activities of the Annual Meeting. Consideration should also be given to inviting a national or state celebrity as a convention speaker.

d. Aid in the preparation of speeches for Medical Society officers and representatives of county societies that do not have a format on news releases, provided two weeks advance notice is given.

e. Development of informative and authoritative announcements and discussions of subjects of general health concern for presentation on New Jersey's TV channels when they become fully operational (Channels 11, 13, 52).

f. Evaluation of the desirability of the preparation on documentaries to improve the image of the physician and to reflect the extent and valuable character of professional services rendered.

g. Establishment of a more direct and personal approach to the members of the press. This might well begin with an annual dinner meeting with all members of the State House press corps invited and with officers of MSNJ and members of the Council on Public Relations attending.

h. Coordination of the county and State public relations systems on issues of controversial importance, and development of a form for reporting of county society activities in the public relations area.

All of the foregoing were approved by the Council and the Board of Trustees for implementation according to the designated schedules. In addition, it was agreed that:

1. A realistic budget would be prepared.

2. Regular and stimulating reminders should be sent to all members of MSNJ advising them that improved public relations for medicine also means intensified personal responsibility of each of them.

3. The Committee on Scientific Sessions of the Annual Meeting should be asked to obtain, in advance of the Annual Meeting, summaries, curricula vitae, and resumés of programed presentations, to be used as advance publicity and to encourage the interest of media representatives.

Filed (page Tr 132)



Officers Dinner—Dr. Campo, Mr. Nevin, Dr. D'Elia



Dr. Slobodien accepting Trustees' Plaque from Board Chairman, Dr. Campo

Special Committees

Emergency Medical Care

Jack R. Karel, M.D., Chairman, Hillside

(Reference Committee "D")

The continued emphasis on Emergency Medical Services in the nation, the increasing volume of patients appearing at hospital emergency departments, and the referral of patients to emergency departments by private physicians have created a need for constant observation and planning.

Interagency Commission on Emergency Medical Care

To this end, a landmark program was initiated by The Medical Society of New Jersey with the formation of the Interagency Commission on Emergency Medical Care. At the invitation of The Medical Society of New Jersey, all the specialty medical societies, allied medical groups, and governmental agencies involved in emergency medicine organized the Interagency Commission on Emergency Medical Care in April 1972. The organizational composition of the Commission is as follows: The Medical Society of New Jersey; New Jersey Committee on Trauma, American College of Surgeons, New Jersey Chapter; American College of Emergency Physicians, New Jersey Chapter; American College of Physicians, New Jersey Chapter; American Academy of Family Practice, New Jersey Chapter; American Academy of Pediatrics; New Jersey Neuro-psychiatric Association; New Jersey Orthopaedic Society; New Jersey State Department of Health; New Jersey Regional Medical Program; New Jersey Hospital Association; New Jersey State First Aid Council and the New Jersey Affiliate, American Heart Association.

In addition to the Commission members, other individuals with expertise in a particular field are members of the following committees: training, communications, emergency departments, organization and planning, public relations, and education and transportation.

The primary purpose of the Commission is to coordinate on a statewide basis medical, allied medical, and governmental agencies involved in the delivery of emergency medical care in all its aspects, to improve upon the current disorganized emergency health care system. A major objective is the development of a total State Plan on Emergency Medical Services, since none exists at the present time.

The initial funding of this Commission was a grant of $2,500 from the Division of Emergency Health Services, Region II, Health Services and Mental Health Administration.

As the Commission progressed, it recognized that various projects needed to be established if the major objective is to be accomplished. In addition, the Commission became the technical advisory body for the New Jersey Regional Medical Program, with additional funding from that agency. Unfortunately, this agency is being phased out by the Federal Government. With the end of its first year of operation, the continued work of the Commission will depend upon the acquisition of further funding.

Emergency Medical Identification

The Committee's Emergency Medical Identification Program conducted in cooperation with Region II, Division of Emergency Health Services, HSMHA, was the most successful in the nation, reaching more people than had any previous program. In addition to distribution from the office of the MSNJ of over 100,000 pieces of literature and identification cards, various organizations and companies duplicated for their membership and employees

EMI material submitted to them. The list includes the New Jersey Bell Telephone Company, New Jersey Division of Civil Defense and Disaster Control, New Jersey State AFL-CIO and affiliated unions, New Jersey State Health Department, New Jersey Pharmaceutical Association, New Jersey State First Aid Council, New Jersey Hospital Association, and the Newark Star-Ledger.

Hospital Signs on Major Highways

The MSNJ continues to emphasize the need for the placement of hospital signs on major highways. Coordination of this program throughout the state is the responsibility of the State Department of Transportation. Further action by that agency is required to complete the project.

Emergency Telephones on Major Highways

Installation of telephones for emergency use (other than coin boxes) is urgently needed. The New Jersey Bell Telephone Company will install this equipment when requested by the Office of Highway Safety and the State Department of Transportation.

Training Program for Medical Technicians in Hospital Emergency Departments

The Special Committee on Emergency Medical Care has been working on the development of a two-year program for the training of hospital emergency department medical technicians in cooperation with Union College in Cranford. Hospitals were surveyed and indicated their interest in hiring a substantial number of emergency department medical technicians. The committee envisioned a course in three parts: basic sciences, clinical sciences, and intensive training in the hospital emergency department. This position could be classified at the Federal GS-6 level.

Establishment of an Emergency Medical Care Center at the New Newark Airport

The present plan of the Newark Airport is to call upon all the rescue squads in the area in time of disaster to provide transportion to the area hospitals. The Committee is of the opinion that expanded size of the new airport and the increasing number of flights that will be involved, require that an emergency medical care center be established at the New Newark Airport itself.

Hospital Emergency Departments

The emergency department of a general hospital having become the most significant section of the hospital, the Board of Trustees approved a most important recommendation as follows: (a) that a fully developed emergency room and department of a general hospital be recognized as a separate clinical department, and further (b) that this department be headed by a qualified physician director.

Standardized Hospital Forms

Since it would be advantageous for hospitals to use standardized forms, the Board of Trustees approved the Committee's recommendation for the establishment of standardized emergency department records for the purpose of statistical analysis.

Section on Emergency Medicine

For several years there has been an upsurge in the field of emergency medical services, both academically and in planning. All physicians and allied medical personnel have a need for training in life-saving procedures. Numerous physicians throughout the country are presently limiting their practice to emergency medicine. In New Jersey there are at present 158 active members in the state chapter of the American College of Emergency Physicians. The national office of the American College of Emergency Physicians has announced that continuing education requirements of 150 hours over a three-year period has commenced on January 1, 1973. The Annual Meeting of the MSNJ would provide an ideal time to reach the greatest number of physicians. Therefore, the following is submitted:

Recommended

That The Medical Society of New Jersey establish a Section on Emergency Medicine.

Approved (page Tr 131)

Filed with notations (page Tr 131)

Medicine and Religion

Watson E. Neiman, M.D., Chairman, Cinnaminson

(Reference Committee "D")

The American Medical Association Committee on Medicine and Religion was abolished during the year. No State meetings were held.

Filed (page Tr 131)

Physicians' Relief Fund

Joseph J. Kline, M.D., Chairman, Trenton

(Reference Committee "B")

The Committee on Physicians' Relief Fund is pleased to report that distribution has been made to each Component Society of the following materials: Rules governing the Physicians' Relief Fund, the Manual for the Preparation of the Application for Financial Aid, and a supply of applications for Financial Aid. There have been no applications received as of the date of this report.

The Committee requested that each Component Society inform its members of the existence and availability of the Physicians' Relief Fund of The Medical Society of New Jersey by placing an announcement in its monthly bulletin.

The financial activities of the Fund during the year are included in the report of the Treasurer.

The Committee wishes to remind the members that it is not the intent of this program to supplant or in any way to interfere or compete with the Society for the Relief of Widows and Orphans of Medical Men of New Jersey. The Committee urges all members of the Society to become sustaining members of that excellent organization.

Filed (page Tr 128)

Project Hope/Vietnam

Thomas C. DeCecio, M.D., Chairman, Cliffside Park

(Referenee Committee "B")

No applications were submitted this year to the Committee. Consequently, no meetings were held during the administrative year.

Filed with notation (page Tr 128)

Retirement Plan for Physicians

Nicholas E. Marchione, M.D., Chairman, Vineland

(Reference Committee "C")

This year has been marked by inactivity on the part of the government with reference to changes in the retirement plans available for physicians either under Keogh or under the corporate master retirement plan.

It has been hoped that by Congressional action the tax-exempt $2500 limit set by law would be increased to $5000. This has not materialized although to the best of our knowledge there are indications that this might happen in the near future to offset some of the benefits accruing from corporate retirement plans.

There has been no annual report from the PRO program as of this date. However, there has been a report from E. & W. Blanksteen Agency, Inc., concerning the Prudential plans as approved by The Medical Society of New Jersey; namely, Plan Trust A and Plan Trust B—a copy follows this report. Of note in their report is that the Prudential Keogh Plan continues to grow and has a very good acceptance among the members because of its flexibility and over-all low cost. The flexibility seems to be a built-in feature allowing doctors to take advantage of market conditions by switching out of variable accounts to fixed dollar funds at favorable unit values. In the event of a market break, the same flexibility allows the participant to reverse the process. Guidance along these lines is furnished by the management as seen fit during anticipated changes in the investment market.

HR-10 (Keogh) Variable Annuity Retirement Investment Plan

The Medical Society of New Jersey Retirement Plan Trust A was established by the Society in 1970 to provide for all members of the State Society the Keogh Program of the Prudential Insurance Company of America, featuring the group Fixed-Dollar Annuity and the group Variable Annuity with E. & W. Blanksteen Agency, Inc., as Administrator. This program had originally begun in Essex and Union Counties where it had achieved widespread acceptance by the members.

The program includes three unique advantages in addition to the well-known tax saving and tax-shelter features of the Keogh Law.

1. A lifetime monthly variable payout, based on a common-stock portfolio. (The Variable Annuity)

2. A death benefit guarantee, so that if the participant dies during the accumulation period, his beneficiary will never receive less than the amount the participant has paid in.

3. Flexibility during accumulation years, permitting the allocation and transfer of funds, at your option, to and from the common-stock account and the fixed-dollar account.

Internal Revenue Service approval for the Master Plan (with Serial Number 701115) was received November 30th, 1970.

Throughout the State we have 277 plans in effect covering 359 people with $1,824,018.61 deposited by members of this program since inception.

Corporate Master Retirement Plan

The Society has recognized that some of its members may see fit to practice in the form of a corporation. Therefore, the Committee recommended and the Society approved, in 1970, the establishment of The Medical Society of New Jersey Retirement Trust Plan-B, which adopted a Corporate Master Retirement Plan using the same funding agents as the Keogh program described above. This program in the form of a Master Profit-Sharing Plan permits corporations, one of whose employees is a member of the Society, to place up to 15 per cent of payroll in a tax-sheltered program with the same flexibility and options as our Keogh program using the Prudential Insurance Company's group Fixed-Dollar Annu-

ity and group Variable Annuity. Some of the useful and valuable features of this Master Plan are here described.

1. Eligibility Requirements—Employment 0 to 5 years —Minimum age up to 30

2. Flexible Retirement Date (especially valuable for older corporate officers)

3. Choice of contribution formulas including *Social Security integration.*

4. Vesting can be as minimal as nothing for the first five years under the plan and then 10 per cent a year for the next ten years.

This plan is administered by E. & W. Blanksteen Agency, Inc., who will be pleased to furnish members with full information concerning this plan which should provide a substantial saving since it is not necessary to have a plan and trust especially drawn for you. Many large corporations and other organizations use these same funding agents for their tax-deferred retirement plan including that of our Administrator.

Filed with notation (page Tr 129)



Officers' Dinner



President D'Elia, Incoming President Boylan, Mrs. Boylan, Mrs. D'Elia

Medical-Surgical Plan of New Jersey

Joseph P. Donnelly, M.D., President, Newark

(Reference Committee "C")

New Jersey Blue Shield in partnership with its participating physicians, in 1972 completed 30 years of successful service for the people of New Jersey.

In our 30th year, four-fifths of the state's physicians were participating in our basic fee program and two-thirds of the physicians in our prevailing fee program.

During 1972 we moved into the position of serving more than 3,700,000 members, or more than half the population of New Jersey. We remained the fourth largest Blue Shield Plan in the nation.

Since our enrollment at year-end of 1942, our first year of operation, was about 4,000, we have grown almost 1,000 fold in our 30-year history.

In reviewing the 30-year history of the Medical-Surgical Plan of New Jersey, I should like to pay tribute to the great contributions the practicing physician has made to the success of our Plan, and to the medical care of its 3,700,000 subscribers. There would be no Blue Shield Plan of New Jersey today were it not for the dedicated physicians who helped found it, and the many others who gave time, effort, and dedication during the last thirty years.

My respect for these men has never diminished, but has continually increased during my lifetime. While New Jersey Blue Shield was organized by physicians, it is clear in every document, as well as etched in the memories of those of us who were around at that time, that the primary purpose of those physicians in establishing Blue Shield was to serve the public and to provide the people of New Jersey with a nonprofit prepayment health insurance plan which would enable them to pay for their own private medical care at a reasonable rate.

All physicians can be proud that they are members of a profession which shares the major responsibility for helping to build a strong system which provides the public with relatively easy access to private medical care with its important physician-patient relationship.

Simply stated medicine's contribution to Blue Shield includes the following:

1. It helped Blue Shield become established as a nonprofit prepayment health insurance plan for the benefit of the public.

2. In certain Plans, including our own, medicine accepted reduced payments to keep the Plan from financial disaster in its early years.

3. It contributed untold hours to Blue Shield Board and committee functions, without charge, to develop programs that the public needed. As one veteran Blue Shield Board member told me, "I serve on the Blue Shield Plan Board because I feel it is my responsibility as a physician. I wouldn't spend the hours I do on Blue Shield matters to take some of the criticism I have to take if I didn't believe I had a professional duty."

4. Medicine has also provided judicial committees to help establish claims review guidelines and to adjudicate difficult cases.

5. Physicians signed participating agreements with Blue Shield. This gave Blue Shield an opportunity to help provide service benefits to the public.

Now what has Blue Shield done for medicine? I can draw an equally impressive list.

1. Blue Shield has given the leadership to, and participated largely in, the development of the world's largest and most viable private system for financing private medical care.

2. Blue Shield and the other voluntary insurance carriers have provided a great bulwark against the enactment of National Health Insurance as it was envisioned 25 years ago by the Murray-Wagner-Dingel Bill, and today by Senators Kennedy, Javitz, and Congresswoman Griffiths. If and when a National Health Insurance Bill is passed, I feel that it will not be a federally-financed and federally-controlled bureaucratic system of medical care.

I remember distinctly when President Harry Truman was elected in 1948 with a liberal Congress and many persons predicted that within two years we would have the Murray-Wagner-Dingel Bill. It hasn't been passed yet, and I predict that the Kennedy-Griffiths Bills won't be passed this year.

When history is written, I think it will be acknowledged that Blue Shield and other voluntary insurance programs played an important role in shaping the medical care system of the United States.

3. Blue Shield, through the voices of physicians on its Board and committees, has been receptive to medicine's views as to how medical care to the public can best be delivered.

4. It has undertaken experimental activities to extend prepayment coverage into new areas of medical service.

5. Blue Shield is working with medicine to develop more effective cost containment programs. Our cost containment programs are not efforts to harass physicians as some Blue Shield critics charge. We understand and respect the role both Blue Shield and medicine must play in utilization review and we are working with doctors to develop efficient claims review and peer review that will be beneficial to everyone.

From these two lists it is obvious that Blue Shield and medicine need each other. In the face of challenges confronting both of us I would urge a re-examination and understanding of Blue Shield as an organization to serve the public's health care needs through a coordinated effort between medicine and Blue Shield.

Since 1968, the New Jersey Blue Shield Plan has written a so-called "Hold Harmless" prevailing fee program for the United Auto Workers and United Steel Workers National Accounts. Probably the term "Hold Harmless" was itself responsible for a misunderstanding by the medical profession. Perhaps a much better name for the program would have been "Fair Fee Program with Peer Review."

The Plan entered into contracts with the employees in those national accounts under which it would be responsible for paying the doctor's bill in full after it is approved either by the Plan, the Judicial Council or the courts, as a just and proper fee, unless the doctor and the patient have entered into a prior agreement on a definite fee, then the Plan will make payment directly to the subscriber and it is up to the patient to pay the doctor's fee in full.

As has been stated: "In New Jersey, Blue Shield will not contest a fee if there has been a documented prior agreement reached by the doctor and the patient. We urge that physicians discuss fees for covered services in advance as much as possible particularly if these fees are above the usual and customary fees in that area. This will avoid this particular problem with Blue Shield contracts with the United Auto Workers and Steel Workers Union."

Despite all the tumult concerning the hold harmless contract, which applies to 132,000 people, or less than four percent of the total Blue Shield enrollment, and the fact that we have already settled a hundred thousand claims under the hold harmless contract, in only one case has the issue ever been settled in court. This was a case in which the doctor involved brought suit and refused to go to peer review. Let me reiterate that under no condition will the Medical-Surgical Plan of New Jersey provide assistance to a subscriber

who seeks to institute legal action against the physician. The charge that the Blue Shield Plan encourages patients to sue physicians is completely devoid of truth and fact.

The year 1972 was when the Plan grew in every way and certain unanticipated changes permitted our reserve to grow to $19,900,000. There were six factors responsible for the increased reserve. They were: increased enrollment, a decline in obstetrical services, a stabilization of utilization of surgical services, stricter policing of payments for laboratory and x-ray services under Rider J, experience rating of large groups and additional investment income.

These items increased the reserve by about $7,000,000 during a two-year period. This reserve amount enabled us to start planning in late 1972 for an improved basic fee schedule. Staff and the Fee Committee have been aware that payments under the 500 and 575 Contracts were below the usual fees charged by a physician.

After a five-month study of these schedules, the Fee Committee approved in February, 1973 some 400 upward revisions for infrequently performed procedures for which the payments had been inequitable. These changes brought the payments into a better relative relationship with the rest of the schedule. In addition, following relative value adjustment a five per cent increase in all medical, surgical, obstetrical, and specific anesthesia payments for services in both schedules was implemented. All changes were made effective for services rendered on and after April 1, 1973, and they will increase the annual payments for physicians' services by some $7,000,000 annually.

The Plan is also developing a new service benefit fixed fee-for-service contract with higher income levels and a higher fee schedule which will extend service benefits to more of the population of the State of New Jersey.

This new program should be completed in time to present it to the House of Delegates' meeting in May, 1973.

Again may I thank all the members of The Medical Society of New Jersey for their cooperation during the past years.

Utilization Review Program

An efficient system of Utilization Review is a necessity for the successful operation of Blue Shield because it has been repeatedly shown that increased costs of physicians' services have been due more to the percentage of increase in utilization than to an increase in physicians' fees.

Both The Medical Society of New Jersey and the Blue Shield Plan oppose those increased costs of medical care which are due to unnecessary physicians' services and to physicians charging for services which they have not performed. The Plan must always be on the alert for that small number of physicians (less than one per cent) who unnecessarily escalate the cost of medical care.

We are happy to report that in 1972 for the first time the utilization of surgical services did not increase. This was due in part, we believe, to the active audit and tissue committees of hospital staffs which are making sure that all surgical procedures are justified. By stabilizing the escalation of surgical services in 1972, about $1 million was added to the Blue Shield reserve. This was a significant portion of the $7 million which will be used to make adjustments in the relative values of the basic schedules and to make the five per cent increase in the 500 and 575 fee schedules.

The Plan's ongoing physicians' Utilization Review Program widened its scope of activities in 1972. New activities included devising a new system of selecting claims for post audits and an acceleration of the Plan's educational programs.

Effectiveness of the program—Prevention, detection and elimination of overuse, abuse of services or even possible fraud are within the

scope of responsibilities of the Utilization Review Section. The measure of effectiveness of the Utilization Review Program would be contingent upon the extent that the medical profession and the general public was made aware of this cost control mechanism.

The deterrent approach produces the best effect.

To achieve optimum results, every means possible was employed to let physicians, the subscribing public and enrolled Groups know that we do have a viable Utilization Review Program. Such means include pre and post audits of every type of claim, Flip Chart presentations, special meetings with physicians, correspondence with the public, as well as with physicians and hospital administrators and with medically oriented personnel such as Medical Librarians and Medical Assistants. To further implement our program, liaison has been established with both the State of New Jersey Department of Institutions and Agencies and the State Board of Medical Examiners. Thus, the Plan is immediately notified whenever a doctor has been suspended for abuse of Medicare.

Refunds—During 1972, exactly $97,055.43 was refunded by 142 doctors. This includes one refund of $30,000. Included is $700 of Federal Government monies, which was subsequently passed on to them. Not included in the above is $8,990 which has been requested from 24 different doctors. Because refunds act as a deterrent and have a cumulative effect, the actual saving to the Plan is far in excess of the above figures.

In addition, it was possible to document reviews. Thus a combination of $97,055 in actual cash refunds and the above-cited $178,056 represents a real savings to the Plan of over one quarter million dollars during 1972.

Diagnostic Clinics—Because certain Diagnostic Clinics are and have been conducting extensive advertising campaigns advocating "Complete Physical Examinations" and because Rider J is particularly vulnerable in this area of x-rays and laboratory tests, attention has been focused in this area. A study is currently under way to select those clinics which are high volume with a view of conducting personal visitations of an educational nature. It is felt that this approach will act as a restraint to overuse of laboratory services.

Flip Chart Presentation—The presentation has been given at all but 22 New Jersey hospitals and arrangements are being made to give the presentation at these hospitals. In a number of instances, the talk was given to the Utilization Committee and an invitation was later extended to repeat it at a full staff meeting. Presentations also are planned for each of the 17 chapters of the American Association of Medical Assistants (AAMA).

In addition to talks at hospitals, presentations were given to selected management personnel at Ingersoll-Rand, Phillipsburg, The Singer Company, Finderne and Esso Systems and Mathematics facility in Florham Park. We have plans to expand this program as part of our subscriber education.

Post Audit of Hospital Charts—One hundred forty-two routine audits were conducted at 97 New Jersey hospitals. Two audits were done at 45 hospitals. Additionally, 61 special audits were done at 45 hospitals. Almost 9,000 hospital charts and close to 22,000 service reports were examined.

Educational Poster Program—A plan has been developed for a series of posters depicting the various aspects of utilization review. These posters would be distributed to enrolled groups at various intervals for posting in a conspicuous location in their plants.

Miscellaneous Activities—An updating of an analysis of anesthesia and pathology arrangements at all New Jersey hospitals was completed. Accordingly, the particular arrangements at any hospital in these two fields of medicine are readily available.

Physician Relations Program

The aim of Physicians Relations is to establish continuing communication between the members of the medical profession and the Plan. Achievement of this objective is vested with Physicians Relations Representatives. Office backup is provided by the Physician's Record Unit, the Physician's Service Unit for telephone and correspondence inquiries, and the Physician's Prevailing Fee Unit.

During 1972 there were 1,008 visits to physicians' offices mainly at physicians' requests. The figure represents a 15 per cent increase over the previous year.

There were 261 meetings with groups of physicians or their paramedical assistants, a 40 per cent increase over 1971.

By means of a more active and diversified field program, we were able to contact and provide service to 1,302 physicians. This represents a 17.6 per cent increase in field contacts for a total of 8,427 contacts in 1972. The total number of participating physicians in both programs now stands at an all-time high.

Physician Representatives worked throughout the year to increase participation in the prevailing fee program in which two-thirds of the state's physicians participated at year-end. Fees paid under this program are the usual, customary or reasonable charges of 90 per cent of the physicians and cover in full 90 per cent of the eligible services rendered under the program, regardless of the subscriber's income.

We would like to take this opportunity to thank our participating physicians for their cooperation, loyalty and dedication.

Enrollment Report

Total membership of Medical-Surgical Plan was increased in 1972 by 228,619 persons, representing a net gain of 6.5 per cent. This was the result of the addition of 98,908 contracts during the 1972 marketing period. Current Plan membership of 3,722,167 persons represents 50.3 per cent of the state's population.

Enrollment under the various Group programs totals 2,966,853 persons, an increase of 184,253 members over the 1971 year-end total. Members of local groups covered under the Basic Certificate, both with and without Rider coverage, total 1,466,647, an increase of 26,119. In addition, growth from the Experience Rating system and the Prevailing Fee Program, increased total membership in local groups by 37,445 persons to 1,645108.

An increase of 84,196 members in the governmental coverages was achieved primarily as a result of the 75,985 members added to the State Municipal Program. The National Account category, including the New Jersey Bell and Western Electric Accounts, displayed a total membership increase of 64,280 members, bringing the total to 634,059.

Subscribers and dependents covered under Domestic Master Contracts totaled 948,703 members at year-end, an increase of 721,435 over the December 31, 1971 total. Most of this gain was due to the conversion of large community groups to Domestic Master Experience Rated contracts during 1972. At year-end, 72 per cent of the Domestic Master Contract membership had Rider J coverage and 19 per cent were enrolled in the Prevailing Fee program which now covers 186,646 locally rated members.

Enrollment with the Group Complementary coverage categories remained relatively stable throughout the year reporting a net decrease of 794 contracts.

During 1972, the total number of Groups enrolled increased by 380 to a total of 17,596.

The Direct Payment categories also displayed similar levels of growth with a gain of 44,366 members during the year bringing currently membership to 725,314. The largest growth was shown in the under age 65 category which grew by 31,040 to 554,836 members; 63

per cent of these members also have Rider J coverage. The Non-Group segment grew by 24,105 members. Left Group enrollment increased by 7,907 whole student members decreased by 972. The senior citizen population enrolled under the Blue Cross and Blue Shield 65 program continued its growth during 1972 with 13,326 new members joining. Of the 170,478 members covered by this program, 75 per cent have also selected the Extended Benefits Rider to supplement their basic coverage.

With a renewed level of stability being forecast for the economy in the current year, it is anticipated that growth in 1973 will show improvement over the 1972 level reported.

Annual Statistics

Table I
Distribution of All Underwritten Services and Payment Paid 1972

Type of Service	Total Services	% All Services	Payment	Percent	Payment Per Service
Surgical	768,333	34.6	$39,708,058	48.2	$ 51.68
Medical	1,173,732	52.9	26,497,890	32.1	22.58
Obstetrical	40,274	1.8	7,829,570	9.5	194.41
Consultation	67,227	3.0	1,472,484	1.8	21.90
Anesthesia	171,101	7.7	6,910,925	8.4	40.39
Total	2,220,667	100.0	$82,418,927	100.0	$ 37.11

Table II
Distribution of Community Rated Rider Services and Payments Paid 1972

Type of Service	Total Services	% All Services	Payment	Percent	Payment Per Service
Surgical	77,783	14.5	$1,486,009	19.2	$ 19.10
Medical	5,397	1.0	277,597	3.6	51.44
Diag. X-Ray	206,869	38.7	3,529,761	45.7	17.06
X-Ray Therapy	1,112	.2	181,488	2.4	163.21
Physical Therapy	12,123	2.3	271,188	3.5	22.37
Pathology	231,883	43.3	1,979,216	25.6	8.54
Total	535,167	100.0	$7,725,259	100.0	$ 14.44

Table III
Distribution of Earned Subscription Income

Earned Subscription Income	$109,123,720	100 %
Incurred Claims	88,936,209	81.5%
Operating Expense	13,090,531	12.0%
Underwriting Gain	7,096,980	6.5%

Following is the experience for 1972:

Claims

Total Claims 1972	Received	Declined	Returned Incomplete
	25,562	3,345	2,191

Paid

Claims	Amount	On Hand
20,508	$1,932,518	827

Federal Employee Program

Following is a statement of income and expense, along with utilization statistics of the 1972 experience of the Federal Employee Program.

Income	$5,439,458	100.00%
Claims Incurred	4,647,228	85.43
	$ 792,230	14.57
Operating Expense (Estimate)	491,068	9.03
Gain	$ 301,162	5.54%

Paid Basis

Average Exposure (Persons)	125,498
Services per 1,000 Persons Enrolled	626
Average Cost Per Service	$ 61.89
Number of Services	78,541
Amount Paid	$4,861,014

Claims Incurred

Year	Incidence Per Thousand	Amount
1972	389	$88,936,209
1971	421	86,036,482
1970	401	80,369,777
1969	328	72,580,000
1968	304	58,536,000
1967	275	53,016,000
1963	193	40,991,000
1960	166	31,516,000
1957	143	22,886,000
1954	126	13,992,000
1951	112	6,527,000
1948	96	1,204,000
1945	86	208,000
1942	40	5,000

Civilian Health and Medical Program of the Uniformed Services

Effective December 1, 1967, the Plan, with the approval of The Medical Society of New Jersey, was designated as contractor for the program, which on the same date adopted a usual and customary charges basis of payment, replacing the fixed fee schedule previously utilized.

Comparative Balance Sheet—December 31, 1972

Assets	*1972*	*1971*
Cash	$ -0-	$ 2,188,910
Investments	43,453,102	30,776,162
Accounts Receivable—Subscriptions	2,144,368	1,744,293
Accounts Receivable—National Account Program	4,818,529	4,055,252
Accounts Receivable—Federal Employee Program	1,773,100	2,128,400
Accounts Receivable—Other	121,421	330,658
Accrued Interest and Dividends Receivable	660,637	436,559
Total Assets	$52,971,157	$41,660,234

Liabilities		*1972*		*1971*
Claims Outstanding:				
Reported	$ 4,282,000		$ 4,155,304	
Unreported	14,737,000		13,413,000	
National Accounts	2,574,000	$21,593,000	2,331,000	$19,899,304
Unearned Subscriptions		4,247,819		4,579,847
Accounts Payable—Miscellaneous		3,851,961		2,899,394
Reserve for Group Contract Settlements		1,915,999		1,856,588
Deposits From Other Organizations		1,475,154		973,656
Total Liabilities		$33,083,933		$30,208,789

Reserves	*1972*	*1971*
Securities Valuation	$ 1,331,650	$ 936,868
Special Contingent	100,000	100,000
Unassigned	18,455,574	10,414,577
Total Reserves	$19,887,224	$11,451,445
Total Liabilities and Reserves	$52,971,157	$41,660,234

Comparative Summary of Operations

		1972			*1971*	
Subscriptions Earned*		$109,123,720	100.0%		$101,481,063	100.0%
Less:						
Claims Incurred**	$88,936,209		81.5	$86,036,482		84.8
Operating Expenses***	13,090,531		12.0	11,848,195		11.7
		102,026,740	93.5		97,884,677	96.5%
Gain from Underwriting Operations		$ 7,096,980	6.5%		$ 3,596,386	3.5%
Income on Investments		2,198,194			1,718,475	
Operating Gain for the Year		$ 9,295,174			$ 5,314,861	

*The gain of $7,642,657 in subscriptions earned reflects gain in enrollment, which increased by 228,619 during the year.

**Claims incurred during the year increased by $2,899,727.

***The increase of $1,242,336 in operating expenses is caused by increased services rendered by Hospital Service Plan in the amount of $600,078 and an increase of $642,258 in Medical-Surgical Plan direct expenses. Based on subscriptions earned, the percentage of total operating expense increased by 0.3%.

Summary of Reserves for Protection of Subscribers

		1972		*1971*
Reserve at January 1		$11,451,445		$ 5,520,123
Operating Gain for the Year		9,295,174		5,314,861
		$20,746,619		$10,834,984
Reserve Adjustment				
Non-Admitted Assets	$(1,142,987)		$120,173	
Unrealized Capital Gains	274,076		196,288	
Miscellaneous	9,516	(859,395)	—	616,461
Reserve at December 31		$19,887,224		$11,451,445

Distribution of Membership
December 31, 1972

County	Group	Non-Group
Atlantic	1.1%	3.1%
Bergen	8.5	11.7
Burlington	1.2	4.0
Camden	2.3	6.7
Cape May	.2	.9
Cumberland	1.6	1.6
Essex	19.7	15.1
Gloucester	.5	2.7
Hudson	6.6	8.8
Hunterdon	.8	7.0
Mercer	25.6	6.9
Middlesex	5.8	7.6
Monmouth	2.7	6.2
Morris	3.1	2.6
Ocean	1.1	3.2
Passaic	4.2	5.2
Salem	.6	.9
Somerset	1.4	2.3
Sussex	.3	.8
Union	10.7	8.6
Warren	2.0	.4

Enrollment Growth

1972	3,722,167
1971	3,493,548
1970	3,414,278
1969	3,369,472
1967	2,908,799
1963	2,450,755
1960	2,080,582
1957	1,711,834
1954	1,196,804
1951	669,906
1945	236,604
1942	4,131

Other Highlights of 1972

Payments for physicians' services were $88,936,209, a 3.5 per cent increase over 1971.

The number of claims was up from 1,471,000 to 1,600,000, a nine per cent increase.

There was a savings in excess of $100,000 to the Plan through switching from daily to weekly payments to physicians.

Increased benefits were put into effect for extended care facilities.

Planning for the carve-out of auto accident coverage because of new no-fault automobile insurance legislation was begun.

In late year a contract was signed for the creation of Mercer Medigroup, the first Health Maintenance Organization in New Jersey, as an alternate system of prepaid medical care to the regular Blue Shield contract.

Prevailing Fee membership reached 465,000, a gain of 45,000 over year-end 1971, or an almost 11 per cent increase.

The New Jersey Dental Service Plan completed its second full year of operation with more than 37,000 enrolled subscribers and 1972 benefit payments of more than $200,000. Over 2,600 of the state's dentists are now participating.

The new Student Accident program enrolled 43,205 subscribers.

Blue Shield completed its first full year in the new building at 33 Washington Street, which permitted more efficient operation through centralization of facilities.

Two new vice presidencies were created. Francis J. Novak became vice president-operations and W. John Gould was named vice president-finance.

Franklin H. Romaine retired as public relations officer and Mrs. Jean R. Geiger was named to the post, effective early in 1973.

New Jersey Participating and Non-Participating Physicians by County—Basic Program

County	Total Elig. Phys.	PARTICIPATING Total	M.D.	D.O.	D.P.M.	Lab.	NON-PARTICIPATING Total	M.D.	D.O.	D.P.M.	Lab.	% P.P. as of 12-31-72	% P.P. as of 12-31-71
Atlantic	300	293	255	17	16	5	7	6	1			97.6	98.1
Bergen	1344	797	675	71	35	16	547	531	11	3	2	59.3	60.5
Burlington	327	301	240	45	14	2	26	23	3			92.0	91.7
Camden	869	771	514	210	39	8	98	90	5	3		88.7	87.4
Cape May	75	73	58	11	3	1	2	1	1			97.3	94.1
Cumberland	153	143	124	10	6	3	10	9	1			93.4	94.3
Essex	1820	1476	1344	48	67	17	344	336	4	1	3	81.1	81.2
Gloucester	172	153	108	33	9	3	19	17	2			88.9	87.4
Hudson	782	660	599	19	35	7	122	118	2	1	1	84.4	83.5
Hunterdon	75	70	70				5	5				93.3	91.7
Mercer	585	473	435	16	19	3	112	108	3		1	80.8	82.7
Middlesex	635	482	435	24	13	10	153	148		2	3	75.9	75.7
Monmouth	650	480	445	18	14	3	170	163	5	2		73.8	73.7
Morris	560	464	417	27	12	8	96	89	4	2	1	82.8	82.4
Ocean	258	181	154	19	6	2	77	70	5	1	1	70.1	73.3
Passaic	715	541	474	34	27	6	174	170	1	2	1	75.6	74.2
Salem	59	55	46	6	2	1	4	3	1			93.2	92.6
Somerset	262	226	213	5	6	2	36	35	1			86.2	85.6
Sussex	88	84	74	8	1	1	4	4				95.4	94.6
Union	922	703	589	64	42	8	219	215	3	1		76.2	76.9
Warren	67	61	54	3	1	3	6	5	1			91.0	94.8
Out of State	275	261	216	40	4	1	14	14				94.9	94.9
Total	10993	8748	7539	728	371	110	2245	2160	54	18	13	79.5	79.6

Specialty	New Jersey Participating and Non-Participating Physicians by Specialty—Basic Program												
Anes.	504	279	260	19			225	220	5			55.3	52.5
Derm. Syph.	186	124	123	1			62	62				66.6	69.7
Int. Med.	1688	1275	1231	44			413	413				75.5	77.0
Neur. Surg.	92	64	64				28	28				69.5	70.8
Obst. Gyn.	830	658	638	20			172	170	2			79.2	77.5
Ophth.	384	247	243	4			137	137				64.3	65.7
Orth. Surg.	377	261	254	7			116	115	1			69.2	65.2
Otol.	238	162	154	8			76	75	1			68.0	69.2
Path.	219	180	175	5			39	38	1			82.2	84.4
Ped.	637	563	556	7			74	74				88.3	89.0
Phys. Med.	30	26	24	2			4	4				86.6	84.6
Plast. Surg.	54	24	23	1			30	30				44.4	43.7
Ana'y. Labs.	123	110				110	13				13	89.4	90.1
Proct.	40	21	13	8			19	19				52.5	50.0
Psy. & Neuro.	575	405	399	6			170	170				70.4	70.3
Radiology	350	284	273	11			66	66				81.1	80.5
Surg.	1061	840	811	29			221	220	1			79.1	77.7
Thor. Surg.	59	44	44				15	15				74.5	72.5
Urol.	264	153	149	4			111	111				57.9	55.1
Podiatry	389	371			371		18			18		95.3	94.9
General	2893	2657	2105	552			236	193	43			91.8	91.6
Total	10993	8748	7539	728	371	110	2245	2160	54	18	13	79.5	79.6

New Jersey Participating and Non-Participating Physicians by County—Prevailing Fee Program

County	Total Elig. Phys.	PARTICIPATING					NON-PARTICIPATING					% P.P. as of 12-31-72	% P.P. as of 12-31-71
		Total	M.D.	D.O.	D.P.M.	Lab.	Total	M.D.	D.O.	D.P.M.	Lab.		
Atlantic	300	247	218	13	12	4	53	43	5	4	1	82.3	82.6
Bergen	1344	666	569	57	28	12	678	637	25	10	6	49.5	50.9
Burlington	327	246	192	41	11	2	81	71	7	3		75.2	77.8
Camden	869	665	445	180	33	7	204	159	35	9	1	76.5	72.8
Cape May	75	55	44	7	3	1	20	15	5			73.3	67.6
Cumberland	153	123	107	8	5	3	30	26	3	1		80.4	80.9
Essex	1820	1236	1127	38	52	12	591	553	14	16	8	67.9	67.9
Gloucester	172	129	88	30	9	2	43	37	5		1	75.0	71.8
Hudson	782	550	499	16	30	5	232	218	5	6	3	70.3	70.4
Hunterdon	75	60	60				15	15				80.0	78.0
Mercer	585	420	386	14	17	3	165	157	5	2	1	71.8	73.4
Middlesex	635	408	368	20	12	8	227	215	4	3	5	64.2	64.5
Monmouth	650	409	382	14	11	2	241	226	9	5	1	62.9	63.5
Morris	560	385	344	24	10	7	175	162	7	4	2	68.7	68.5
Ocean	258	155	134	17	4		103	90	7	3	3	60.0	51.5
Passaic	715	463	411	29	20	3	252	233	6	9	4	64.7	63.8
Salem	59	48	40	5	2	1	11	9	2			81.3	81.4
Somerset	262	191	179	5	5	2	71	69	1	1		72.9	68.9
Sussex	88	68	61	6	1		20	17	2		1	77.2	82.6
Union	922	554	464	53	31	6	368	340	11	12	2	60.0	61.8
Warren	67	56	51	2		3	11	8	2	1		83.5	86.2
Out of State	275	140	114	23	3		135	116	17	1	1	50.9	49.6
Total	10993	7267	6283	602	299	83	3726	3416	180	90	40	66.1	66.0

New Jersey Participating and Non-Participating Physicians by Specialty—Prevailing Fee Program

Specialty												
Anes.	504	304	286	18			200	194	6			60.3	57.8
Derm. Syph.	186	105	105				81	80	1			56.4	59.4
Int. Med.	1688	1111	1075	36			577	569	8			65.8	65.7
Neur. Surg.	92	52	52				40	40				56.5	59.4
Obst. Gyn.	830	591	574	17			239	234	5			71.2	70.5
Ophth.	384	224	222	2			160	158	2			58.3	58.8
Orth. Surg.	377	198	191	7			179	178	1			52.5	50.3
Otol.	238	128	121	7			110	108	2			53.7	57.7
Path.	219	128	126	2			91	87	4			58.4	56.2
Ped.	637	433	427	6			204	203	1			67.9	69.0
Phys. Med.	30	18	17	1			12	11	1			60.0	61.5
Plast. Surg.	54	16	15	1			38	38				29.6	25.0
Analy. Labs.	123	83				83	40				40	67.4	67.7
Proct.	40	28	22	6			12	10	2			70.0	67.5
Psy. & Neuro.	575	347	342	5			228	227	1			60.3	63.2
Radiology	350	220	211	9			130	128	2			62.8	62.8
Surg.	1061	712	685	27			349	346	3			67.1	65.8
Thor. Surg.	59	33	33				26	26				55.9	56.8
Urol.	264	152	149	3			112	111	1			57.5	56.4
Podiatry	389	299			299		90			90		76.8	77.8
General	2893	2085	1630	455			808	668	140			72.0	71.1
Total	10993	7267	6283	602	299	83	3726	3416	180	90	40	66.1	66.0

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Joseph P. Donnelly, M.D., President

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Executive Vice President
and Secretary-Treasurer

Francis J. Novak, Vice-President—Operations
W. John Gould, Vice-President—Finance

Jerome C. Rothgesser, M.D.
Vice President—Medical Affairs
and Medical Director

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TRUSTEES EMERITUS

	Appointed	*Term as Board Member*
Joseph I. Echikson, M.D.	1970	1954-1970
Elton W. Lance, M.D.	1971	1962-1971
Edward W. Sprague, M.D.	1966	1942-1966
John S. Thompson	1966	1942-1965

ADVISOR TO THE BOARD OF TRUSTEES

	Appointed	*Term as Board Member*
William F. Costello, M.D.	1958	1948-1958

Filed with commendation (page Tr 129)

Supplemental Report

Series 750 Program

The public, the profession, and the Plan urgently need a new Blue Shield Program as an intermediate between its Series 500 and its Prevailing Fee, or Usual, Customary, or Reasonable Program for the following reasons:

1. The Series 500 Program has become outdated from the standpoint of the physicians of New Jersey because payments under it are considerably less than usual and fair fees for the services covered. It is equally outdated to about three quarters of the subscribing public since it represents an indemnity coverage for those families whose gross income is over its $7,500 limit for service benefits.

2. The Prevailing Fee Program which would have satisfactorily eliminated both of the above inadequacies has developed considerable sales resistance in the market place because of its cost. The premium differential between Series 500 and Prevailing Fee Programs is too great to be accepted at a single union-management negotiation.

The Plan's Staff, Fee Committee, and Board of Trustees have exhaustively reviewed many alternatives during the past year and all concerned sincerely believe that the program being presented to this House of Delegates

will offer a satisfactory solution to the current problem from the standpoint of the public and the profession. Series 750 represents a stepping stone to our Usual, Customary, or Reasonable program by giving service benefits to a substantially larger percentage of the public than our Series 500, with a premium rate that can be sold in today's market. It has a fee structure that is fair and reasonable for a fixed fee program with income limits as described.

The target date for implementation is July 1, 1973.

Service Benefits

The following definition of a Service Benefit Subscriber will apply to the 750 contracts:

"An unmarried subscriber covered under a single contract whose income is under $7,500 or all other subscribers whose income including that of spouse, if any, is under $12,000."

Income is defined as:

"The gross annual income from all sources for the last calendar year prior to the year in which the services commenced for which benefits are provided by this Contract."

Fee Schedule

All medical, surgical, obstetrical, and anesthesia fees will be increased to an amount not less than 1½ times the Series 500 fees published in our printed fee schedule dated January, 1970, and used through March, 1973. Many fees will be greater than 1½ times that printed Series 500 fee schedule. A representative sample of the Series 750 fees follows. A more comprehensive sample has been transmitted to The Medical Society of New Jersey and copies will be available at the Plan's Exhibit Booth for review.

Medical Services

In-Hospital Medical Care

1st day of routine medical care rendered	$23.00
1st day of medical care above routine including complete multi-system diagnostic history and physical examination and initiation of diagnostic and treatment programs	30.00
2nd day of medical care rendered	15.00
Subsequent day of medical care rendered (3rd day to discharge)	9.00

In-Hospital Constant and Prolonged Attendance

In-hospital constant and prolonged attendance for necessary medical care, other than terminal cancer—$43.00 per hour. No payment for this service for less than one hour constant attendance. The maximum payment for this service is $215.00.

In-Hospital Intensive Medical Care

1st day of intensive medical care rendered	45.00
2nd day of intensive medical care rendered	30.00
3rd through 14th day of intensive medical care rendered	15.00

In-Hospital Consultation

01 Consultation not requiring a comprehensive medical history and a complete physical examination and not including the detailed study required under Code #02	30.00
02 Consultation requiring a comprehensive medical history and complete physical examination in a case requiring a detailed study due to a diagnostic or therapeutic problem of a serious or complicated nature	45.00
03 Complete neurological examination, complete psychiatric examination or complete neuro-psychiatric examination, either as a consultation or as an initial procedure (when performed by a Psychiatrist, Neurologist or Neuro-Surgeon)	45.00

In-Hospital Medical Care of Newborn

Healthy Newborn Care—(Birthweight over 5 lbs)

Payment eligible only to a physician other than the physician (s) paid for maternity service and when such separate Healthy Newborn Care is not mandatory by hospital regulations. (The Plan's determination as to the mandatory nature of such services will be final) $23.00

Surgical and Anesthesia Fees

Surgical and anesthesia fees follow.

Procedures for which anesthesia is paid using Basic plus Time units will be paid using a conversion factor of $7.25.

The minimum anesthesia fee under this program will be $40.00.

Radiological Services

A new fee schedule for radiology has been approved for this program. Although many fees remain unchanged, most of the major procedures have been substantially increased. Some examples are here listed and the full radiological schedule has been sent to The Medical Society of New Jersey with copies available at the Plan's Exhibit Booth for review.

Pathology Services

Pending complete review of the Plan's laboratory fee schedule the current Rider J fees will be used.

The Trustees of Medical-Surgical Plan of New Jersey therefore **recommend** that the Trustees and House of Delegates of The Medical Society of New Jersey approve the Plan's Series 750 Program.

Surgical and Anesthesia Fees
Series 750

Code	*Procedure*	*Surgery*	*Anesthesia*
0189	Wide excision of lesion without plastic closure	$ 75	$ 40
0190	Face and neck only	113	40
0232	Radical excision of nail	53	40
0238	Excision of pilonidal cyst	188	45
0263	Plastic operation on skin with resection of deep tissue	150	T
0268	Split skin graft 2 to 32 sq. inches, trunk, legs, etc.	150	T
0383	Suture, laceration 1"to 2"	30	40
0445	Partial mastectomy, unilateral	128	40
0470	Radical mastectomy, unilateral	450	T
0740	Clavicle, closed reduction	75	40
0780	Humerus, surgical neck requiring manipulation	150	40
0807	Colles' fracture, closed reduction	90	40
0821	Radius and ulna, shafts, fracture, closed reduction	150	40
0867	Femur, neck fracture, open reduction	450	98
0933	Bimalleolar fracture, closed reduction	150	40
1075	Excision of intervertebral disk and spinal fusion	825	T
1082	Meniscectomy, knee	353	75
1162	Radical bunionectomy, unilateral	173	40
1178	Hammer toe operation, one	113	40
1431	Excision, olecranon bursa	113	40
1555	Ganglionectomy, other than digits	113	40
1867	Plaster cast, foot to thigh	60	—
1931	Rhinoplasty and Septectomy	450	90
1985	Maxillary antrotomy, unilateral	90	40
1988	radical, Caldwell-Luc	300	60
2101	Tracheostomy	150	40
2111	Bronchoscopy, diagnostic	105	45
2193	Lobectomy, lung	750	150
2309	Open heart surgery, cardiac	1125	T
2311	Open heart surgery, thoracic	375	—
2331	Right heart catheterization	150	T
2334	Left heart catheterization with angiocardiography	225	T
2435	Arteriography, retrograde catheter	113	40
2563	Ligation and stripping of long and short saphenous veins	263	T
2601	Splenectomy	375	75
2657	Radical neck dissection	600	120
2992	Tonsillectomy, under age 12	98	40
3115	Gastrectomy, subtotal	525	105
3261	Appendectomy	263	53
3315	Sigmoidoscopy with removal of polyps	75	40
3375	Hemorrhoidectomy, internal and external	165	45
3424	Radical hemorrhoidectomy, entire pile bearing area	255	T
3515	Cholecystectomy	375	75
3571	Exploratory laparotomy	263	T
3631	Inguinal herniorrhaphy, unilateral	225	45
3924	Transurethral resection of bladder tumor	225	53
3935	Cystoscopy, pyelogram	75	40
4122	Circumcision, newborn	15	—
4123	Circumcision, under age 10	53	40
4321	Prostatectomy, transurethral	488	98
4488	Colpoplasty, anterior and posterior	300	60
4545	Salpingo-oophorectomy	300	60
4617	Hysterectomy, total	413	83
4647	Dilation and curettage	90	40
4690	Hysteropexy, Manchester	338	68
4801	Caesarean section	465	78
4821	Vaginal delivery	300	40
4921	Hemithyroidectomy	338	83
5081	Encephalography	113	53
5154	Excision, brain cyst	863	T
5345	Neurolysis	300	60
5613	Extraction of crystalline lens	488	113
5636	Scleral buckling	675	T
5642	Myotomy, ocular muscles for strabismus, bilateral	375	75
5962	Myringotomy, bilateral	45	40
5966	Stapedectomy	488	T

Radiological Fees
Series 750

Code	*Procedure*	
7100	Chest, single view	$10
7104	Bronchography, unilateral (For injection procedure, see 2061)	30
7104	Bronchography, bilateral (For injection procedure, see 2061)	40
7111	Rib, bilateral	25
7253	Humerus, including one joint	15
New	Upper extremity, infant	10
7300	Hip, one view	15
7301	Hip, complete study	25
7306	Ankle, two views	10
7350	Abdomen, single anterior-posterior	15
7358	Upper gastrointestinal tract, (stomach, esophagus, duodenum) with or without delayed films	40
New	with abdomen, single AP view	50
7360	Colon, barium enema, with or without abdomen, single AP	40
7361	Barium enema and air contrast, with or without abdomen, single AP	55

7364}	Cholecystography, oral dye, with or with-	
7369}	out scout film, prior date	30
New	Cholecystography oral dye, with or without scout film, prior date, with fatty meal	35
New	Cholecystography, oral dye, with or without scout film, prior date-multiple day test	50
7372	Urography, intravenous, including kidneys, ureters and bladder, with or without scout film	40
7374	including special hypertensive dye concentration and/or clearance studies, with or without scout film	55
7373	Urography, retrograde, including kidneys, ureters and bladder, with or without scout film	35
7387	Hysterosalpingography	25
	(For injection procedure, see 4676)	
New	Lymphangiogram, unilateral	50
New	Lymphangiogram, bilateral	90
7464	Mammography, bilateral	30
New	Procedures using Xeroradiography Polaroid or similar media, add	10
	(No additional payment for conventional radiography, same area)	
	Teleradiotherapy, less than 1000 KVP, telecesium per treatment	15
	1000 KVP and higher, cobalt, per treatment	20
	Linear accelerator, betatron, etc., per treatment	25
	Brain scan	90
	Kidney scan	75

Filed with commendation (page Tr 129)



House of Delegates—Election Session



Board of Trustees—1973-1974

Nominations for Emeritus Membership

(Reference Committee "H")

The following nominations for election to emeritus membership at the 1973 Annual Meeting have been received from the component societies. Conforming to the provisions of Article IV, Section 6, of the Constitution, all nominees are now and have been members in good standing of a component society for at least twenty years, and by reason of age or infirmity have retired from the active practice of medicine. All are emeritus members of their respective component societies.

Atlantic County

Leo Kahn, M.D., Hollywood, Fla. (formerly Ventnor City) ; Age 66

Bergen County

Joseph F. Duffy, M.D., Oldsmar, Fla. (formerly Westwood); Age 67
Herta Fechner, M.D., Teaneck; Age 65
Herbert E. Fitch, Jr., M.D., Tenafly; Age 58
Robert R. Grimes, M.D., Ridgefield Park; Age 63
R. Bryan Hillsman, M.D., Sarasota, Fla. (formerly Teaneck); Age 66
Bertha P. Rodger, M.D., Clearwater, Fla. (formerly Ridgewood); Age 61
Michael Sarla, M.D., Collegeville, Pa. (formerly Hackensack) ; Age 83
Charles G. Stetson, M.D., Tenafly; Age 64
Russell K. Tether, M.D., Demarest; Age 71
H. H. Vandersluis, M.D., Nokomis, Fla. (formerly Park Ridge); Age 72
Edward E. Wolfe, M.D., Teaneck; Age 69
James L. York, M.D., Rockleigh; Age 69

Camden County

Raul R. Betancourt, M.D. Riverton; Age 70
John P. Rudolph, M.D., Merchantville; Age 61

Cumberland County

John J. Bianco, M.D., Ft. Lauderdale, Fla. (formerly Vineland) ; Age 58

Essex County

Benjamin B. Adelman, M.D., West Orange; Age 71
Frank G. Barnard, M.D., Montclair; Age 63
Franklin J. Besson, M.D., Irvington; Age 64
*Anthony D. Crecca, M.D., Newark; Age 65
Rudolph O. Fager, M.D., Charlottesville, Va. (formerly Bloomfield) ; Age 71
Joseph Goldmann, M.D., Maplewood; Age 66
William H. Hahn, M.D., Southbury, Conn. (formerly South Orange) ; Age 78
Daniel E. Kavanaugh, M.D., Jamesburg; Age 76
Thomas F. Magovern, M.D., South Orange; Age 71
Camille Mermod, M.D., Maplewood; Age 73
Herman P. Miller, M.D., Miami Beach, Fla. (formerly Newark) ; Age 68
Benjamin Polow, M.D., East Orange; Age 71
John V. Reilly, M.D., Newark; Age 69
Mark A. Roston, M.D., Punta Gorda, Fla. (formerly Newark); Age 60
Ludwig L. Simon, M.D., Ft. Lauderdale, Fla. (formerly Newark); Age 73
John H. Wilson, Jr., M.D., Dallas, Texas (formerly East Orange) ; Age 70

Gloucester County

Frederick G. Wandall, M.D., Pitman; Age 71

Middlesex County

Arpad G. Gerard, M.D., Woodbridge; Age 64
Joseph F. Sandella, M.D., New Brunswick; Age 68
Max Schiller, M.D., Hallandale, Fla. (formerly North Brunswick) ; Age 66
William Toth, M.D., Edison; Age 57

Ocean County

Albert Leslie Gibbins, M.D., Beachwood; Age 65

Passaic County

Arthur A. Allen, M.D., West Milford; Age 67
Forrest Spencer Chilton, M.D., Lehigh Acres,

*Deceased May 2, 1973

Fla. (formerly Pompton Plains) ; Age 70
John A. Ianacone, M.D., Paterson; Age 64
Sigurd W. Johnsen, M.D., Passaic; Age 77
Walter A. Kovaleski, M.D., Clifton; Age 65
Dominick Marini, M.D., Passaic; Age 78
Leonard M. Matthews, M.D., Clifton; Age 81
Philip H. Simon, M.D., S. Bal Harbor, Fla. (formerly Passaic); Age 74
George K. Tweddle, Jr., M.D., Fair Lawn; Age 51
Earl L. Warren, M.D., Glen Rock; Age 70
I. J. Wolf, M.D., Paterson; Age 70

Salem County

John S. Dunn, M.D., Salem; Age 70
Lee C. Hummel, M.D., Easton, Md. (formerly Salem); Age 69

Union County

Alexander E. Breslow, M.D., Atlantic Highlands; Age 69
Harry Hoffman, M.D., Silver Springs, Md. (formerly Scotch Plains); Age 64
David F. Reilly, M.D., Elizabeth; Age 71

Approved (page Tr 139)

Supplemental Report

The following additional nominations for election to emeritus membership have been received:

Bergen County

**Leon J. Schwartz, M.D., Rutherford; Age 66

Essex County

S. Wolfe Emmer, M.D., Newark; Age 73

Hudson County

Josef T. Bergmeyer, M.D., Newfoundland; Age 69
John G. Barbarini, M.D., Hoboken; Age 61
Louis J. Garibaldi, M.D., Weehawken; Age 70
John W. McLoughlin, M.D., Lakewood; Age 67
Frank Stefansin, M.D., North Bergen; Age 65

**Deceased February 22, 1973

Approved (page Tr 139)



Incoming President and Mrs. Boylan and their children

MEMORIAL RESOLUTIONS

The following resolutions were received by the House with sorrowful concurrence.

Ralph King Hollinshed, M.D.
(1884-1973)

Whereas, after a long and distinguished life as gifted physician and exemplary humanitarian, Ralph King Hollinshed, M.D., our esteemed and beloved colleague, has been called to his eternal reward; and

Whereas, as former secretary and past president of the Gloucester County Medical Society, member and former President of The Medical Society of New Jersey, and member of the American Medical Association and of the American College of Physicians, Doctor Hollinshed was a life-long worker for the advancement of organized medicine and the elevation of its ideals; and

Whereas, by his gentle, compassionate, and expert services as an outstanding physician, Doctor Hollinshed proved himself as one who loved his fellowmen and was in consequence by them beloved; now therefore be it

RESOLVED, that The Medical Society of New Jersey, honoring Ralph King Hollinshed, in death as in life, records its profound grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of this meeting and that another copy, suitably prepared, be presented to his bereaved family in token of heartfelt sympathy.

Luke Aloysius Mulligan, M.D.
(1902-1972)

Whereas, Almighty God has summoned from our midst his good servant and our beloved colleague, Luke Aloysius Mulligan, M.D.; and

Whereas, as member and Chairman of the Board of Trustees of The Medical Society of New Jersey, member of numerous committees, Chairman of the Committee on Medical Student Loan Fund and the Committee on Medicine and Religion, and Delegate to the American Medical Association, Doctor Mulligan rendered uniformly high and valuable service to The Medical Society of New Jersey and the people of our state; and

Whereas, his generous spirit led him to give further of himself as member and President of the State Board of Medical Examiners and member of the State Hospital Advisory Council; and

Whereas, by his industry, understanding, dependability, and kindness he won the affectionate esteem of all who knew him; now therefore be it

RESOLVED, that The Medical Society of New Jersey, honoring Luke Aloysius Mulligan, M.D., in death as in life, records its profound grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of this meeting and that another copy, suitably prepared, be presented to his bereaved widow in token of heartfelt sympathy.

RESOLUTIONS

#1

Robert's Rules of Order

Seymour F. Kuvin, M.D., Delegate, Essex County

(Reference Committee on Constitution and Bylaws)

Whereas, the Bylaws of The Medical Society of New Jersey were recently amended so that deliberations of this Society shall be governed by parliamentary usage as contained in the latest revision of Sturgis' "Standard Code of Parliamentary Procedure;" and

Whereas, rules, terms, and procedures under Sturgis are unfamiliar to a majority of those participating in the deliberations of our House of Delegates sessions; and

Whereas, as a result, proceedings of our House of Delegates have been hampered, impeded, lengthened, and made unclear; now therefore be it

RESOLVED, that The Medical Society of New Jersey again amend its Bylaws to use "Robert's Rules of Order."

Rejected with notation (page Tr 125)

#2

Establishment of a School of Physical Therapy in New Jersey

Edwin H. Albano, M.D., Delegate, Essex County

(Reference Committee "A")

Whereas, The Medical Society of New Jersey, through action of its Board of Trustees in 1970, recommended the establishment of a School of Allied Health Professions in New Jersey; and

Whereas, physical therapy is an integral and indispensable component of the allied health professions; and

Whereas, the State Department of Higher Education, without consultation with The Medical Society of New Jersey in its "Health Professions Education Master Plan," has recommended against the establishment of such a school in New Jersey; and

Amended by Reference Committee by deletion of obove "whereos" (poge Tr 127)

Whereas, the conclusions of the State Department of Higher Education appear to be based upon inadequate, perhaps erroneous data as to supply and demand projections for physical therapy in this state; and

Amended by Reference Committee by deletion of obove "whereos" (poge Tr 127)

Whereas, the citizens of this state who desire to be trained in this discipline must go out of the state to secure their training; and

Whereas, the College of Medicine and Dentistry of New Jersey is committed to a department of physical medicine and rehabilitation which would be seriously incomplete without a school of physical therapy; now therefore be it

RESOLVED, that The Medical Society of New Jersey, in annual meeting assembled, reaffirm the Board's 1970 recommendation; and be it further

RESOLVED, that The Medical Society of New Jersey urge that this policy recommendation receive the most detailed attention and support so that purely fiscal considerations will not prevail, to the detriment of the quality of medical care offered to the citizens of this State.

Adopted as amended by Reference Committee by deletion of the 3rd and 4th "whereos" (page Tr 127)

Apportionment of MSNJ Delegates

In consequence of the action of the House of Delegates (See p. Tr 53) in adopting the amendment to Chapter 11, Section 4 of the Bylaws, current associate members automatically become active members. At the present ratio of one delegate for each 20 members of a component society, the total number of delegates would exceed the 400 permitted by the Constitution.

Upon motion duly made, seconded, and carried, the matter was referred to the Board of Trustees for evaluation and disposition.

#3

Establishment of a Mechanism to Coordinate Postgraduate Medical Education Programs

From the Essex County Medical Society
(Reference Committee "D")

Whereas, the increased emphasis on postgraduate medical education has engendered a large number of available meetings and courses; and

Whereas, concurrent meetings often designed for similar medical audiences are frequently held in the same locale, resulting in diminished return and increased expense to all concerned; and

Whereas, at the present time there is no official existing statewide coordinating agency which adequately avoids this unnecessary and wasteful duplication; now therefore be it

RESOLVED, that The Medical Society of New Jersey establish a statewide mechanism for clearance of topic, date, and geographic area to avoid duplication of effort in postgraduate medical education; and be it further

RESOLVED, that all parties—medical schools, specialty groups, medical societies, and hospitals—interested in the furtherance of postgraduate medical education be appraised of this coordinating mechanism and advised to use it.

Rejected as unnecessary (page Tr 131)

#4

Support of Interagency Commission on Emergency Medical Care

Clifford B. Blasi, M.D., and Daniel J. O'Regan, M.D.
Delegates, Hudson County
(Reference Committee "D")

Whereas, the Board of Trustees of MSNJ, recognizing the need to coordinate and unify the planning, training, and rendering of emergency medical care in New Jersey, did establish a committee for this purpose: and

Whereas, the Interagency Commission for Emergency Medical Care was established to meet this need; and

Whereas, the Commission, composed of representatives of professional and paraprofessional groups involved in emergency medical care, has been meeting regularly to organize and formulate a statewide plan for training communication, and delivery of emergency medical care; and

Whereas, the New Jersey Regional Medical Program, which has rendered vital financial and administrative assistance to the Commission from the onset, is being phased out under the new federal budget for the Department of Health, Education, and Welfare, on June 30, 1973; and

Whereas, without the support of the New Jersey Regional Medical Program the Interagency Commission may not be able to continue its work; now therefore be it

RESOLVED, that MSNJ continue to support the efforts of the Interagency Commission, including sound financial assistance.

Foregoing "resolved" amended to read (page Tr 131):

Resolved, that MSNJ continue to support the efforts of the Interagency Commission, including financial assistance approved by the Board of Trustees up to $2500 for one year, and that it encourage other participating agencies to contribute to the support of this agency as well.

Adopted as amended by the Reference Committee (page Tr 131)

#5

Death Certificate Law

John B. Movelle, M.D., Delegate, Monmouth County
(Reference Committee "E")

Whereas, there is now a great demand for physicians to care for the medical needs of our citizens; and

Whereas, it is everyone's desire to reduce the cost of medical care by elimination of unnecessary procedures; and

Whereas, our present mechanism for pronouncing patients in nursing homes dead causes a great inconvenience to the funeral directors and nursing home administrators (since they often must wait hours for the arrival of the physician) and an unnecessary expense to the government (since most patients are on Medicare or Medicaid) or family, and an unnecessary burden on the physician (who is already unable to respond to all his calls for lack of time) ; and

Whereas, a professional person (usually an R.N.) at the nursing home has already determined that the patient has expired and has so notified the physician; now therefore be it

RESOLVED, that the present system be changed so that any patient who has been examined and determined to be terminally ill within 48-72 hours of the time of expiring may be pronounced dead by a professional person, i.e. an R.N.; and be it further

RESOLVED, that after consultation by 'phone with the attending physician or his designated alternate the body may be removed from the nursing home by the funeral director.

Rejected (page Tr 132)

#6

Medicaid Payments to Clinics and Physicians

From the Burlington County Medical Society

(Reference Committee "F")

Whereas, Medicaid is paying clinics at a much higher rate per visit than it is paying private physicians for similar services; and

Whereas, private physicians are required to pay all taxes and office overhead expenses; and

Whereas, services of private physicians are generally and more readily available as opposed to the limited hours of public clinics; and

Whereas, the private physician is the foundation of the continuity of medical care; now therefore be it

RESOLVED, that The Medical Society of New Jersey do all in its power to rectify this Medicaid inequity and bring the private physicians' fees more in line with their costs and services.

Reference Committee offered the following substitute resolution for Resolution #6; Substitute Resolution #6 Adopted (page Tr 134)

Substitute Resolution #6

Medical Payments to Clinics and Physicians

Whereas, Medicaid is paying clinics at a much higher rate per visit than it is paying private physicians for similar services, and

Whereas, the total cost to the State for Medicaid care in clinics is greater than the total cost in private physicians' offices; and

Whereas, private physicians are required to pay all taxes and office overhead expenses; and

Whereas, services of private physicians are generally more efficient and more readily available, as opposed to the limited service hours in public clinics; and

Whereas, the private physician is the foundation of the continuity of medical care, and

Whereas, the Medicaid Program is in effect defeating its intent of providing equal care to all patients and is limiting the patients' free choice of physicians, now therefore be it

RESOLVED, that The Medical Society of New Jersey do all in its power to rectify this Medicaid inequity and to bring the payments for services rendered more in line with realistic values, and be it further

RESOLVED, that, concerning this matter, the Council on Medical Services be instructed to consult with the proper State authorities; and be it further

RESOLVED, that The Medical Society of New Jersey continue to encourage uniform high-quality care for Medicaid patients as well as for private patients.

#7

Establishment of a Section on Emergency Medicine

Clifford B. Blasi, M.D., and Daniel J. O'Regan, M.D.

(Reference Committee "H")

Whereas, all physicians have a need to receive training in certain life-saving procedures; and

Whereas, all physicians would benefit from well-planned educational programs in emergency care; and

Whereas, there has been a pronounced increase of interest in the field of emergency medicine by medical students, house staff, and physicians; and

Whereas, numerous physicians are presently limiting their practice to emergency medicine; and

Whereas, the Board of Trustees of MSNJ, recognizing the need to consolidate and unify the planning, training, and rendering of emergency medical care in New Jersey did establish a committee for this purpose; and

Whereas, the Interagency Commission on Emergency Medical Care was established to meet this need; and

Whereas, efforts to provide members of MSNJ with educational programs in emergency medicine have in the past been necessarily a combined effort of several MSNJ sections; and

Whereas, the Annual Meeting of MSNJ would provide an ideal time to reach the greatest number of physicians; now therefore be it

RESOLVED, that a Section on Emergency Medicine be established for the purpose of coordinating educational programs for all practicing physicians.

Adopted with notation (page Tr 139)



Fellows—Satulsky, Bertha, Collins, Kustrup, Jehl, Bedrick, Calvin

#8

Section on Physical Medicine and Rehabilitation

From the Board of Trustees

(Reference Committee "H")

Whereas, it has been reported that there are approximately thirty-five diplomates—or Board-eligibles—of the American Board of Physical Medicine and Rehabilitation practicing in New Jersey; and

Whereas, of the fifty states, New Jersey reportedly has the ninth highest total of practicing physicians in Physical Medicine and Rehabilitation; and

Whereas, as the most densely populated State in the United States, New Jersey has a need for recognition of this specialty; and

Whereas, the New Jersey practitioners of this specialty have formally requested favorable consideration by The Medical Society of New Jersey of the formation of a new Scientific Section on Physical Medicine and Rehabilitation; and

Whereas, the Committee on Annual Meeting of The Medical Society of New Jersey has formally recommended that the Society establish a Scientific Section on Physical Medicine and Rehabilitation; now therefore be it

RESOLVED, that the House of Delegates of MSNJ approve the recommendation of the Committee on Annual Meeting and authorize the formation of a Scientific Section on Physical Medicine and Rehabilitation.

Adopted **(page Tr 139)**

#9

Conferral of Emeritus Title on Richard I. Nevin

From the Hudson County Medical Society

Whereas, Richard I. Nevin has faithfully served The Medical Society of New Jersey as Executive Officer and subsequently as Executive Director from 1951 until the present; and

Whereas, he has performed his duties in an exemplary and superlative manner; and

Whereas, he has given of himself in time and energy far beyond the call of duty; and

Whereas, The Medical Society of New Jersey has already seen fit to recognize his contributions to the profession of medicine and his enhancement of the public regard of the physician's image in our State by granting him honorary membership; and

Whereas, Mr. Nevin is entering upon retirement; now therefore be it

RESOLVED, that in recognition of his superior performance of his duties and accomplishments, The Medical Society of New Jersey confer upon him the title "Executive Director Emeritus", with all the rights and privileges appertaining thereunto.

Adopted by acclimation without referral to Reference Committee

#10

Hospital Readmission of Acute Cases

From the Essex County Medical Society

(Reference Committee "F")

Whereas, patients transferred from acute hospital facilities to nursing home facilities may be under the care of physicians other than their attending physician in the hospital; and

Whereas, the continuity of care may be disrupted and in some instances never re-established with the initial admitting physician; and

Whereas, an acute medical crisis may occur requiring the readmission of the patient to an acute hospital facility; and

Whereas, hospitals have been and are reluctant to readmit such patients; now therefore be it

RESOLVED, that The Medical Society of New Jersey form a committee to meet with the New Jersey Hospital Association to study and devise a mutually acceptable procedure insuring proper disposition of such cases as the need arises; and be it further

Foregoing "resolved" amended by the Reference Committee as follows (poge Tr 134):

RESOLVED, that The Medical Society of New Jersey, through its Liaisan Committee with the New Jersey Hospital Association, study and devise o mutually occeptable procedure to insure proper dispasition of such cases as the need arises; and be it further

RESOLVED, that nursing home administrators and hospital administrators be provided with copies of the results of such agreement.

Adapted as omended by Reference Committee (poge Tr 134)

#11

Medical Testimony

From the Essex County Medical Society

(Reference Committee "E")

Whereas, the statutes of the State of New Jersey provide for the prosecution of physicians who are in violation of the State Narcotics Regulations; and

Whereas, medical testimony is requisite in the establishment of evidence of such abuse; and

Whereas, organized medicine should play an active part in assisting in the prosecution of such offenders; now therefore be it

RESOLVED, that The Medical Society of New Jersey establish a panel of medical experts to be available to the State's Attorney General for the purpose of providing medical testimony in the prosecution of cases dealing with drug abuse.

Reference Committee offered the following substitute resolution for Resolution #11. Substitute Resolution #11 odopted (page Tr 132)

Substitute Resalutian #11

Medical Testimany

Whereas, drug abuse control statutes of the State of New Jersey provide for the prosecution of persons who are in violation of those stotutes; ond

Whereas, medical testimany is often requisite in the establishment of evidence of such abuse; and

Whereos, organized medicine should play an active port in assisting in the litigotion of such cases, now therefare be it

RESOLVED, that The Medical Saciety af New Jersey develap a list af medical experts ta be available far the purpose of praviding medical testimany in cases dealing with drug abuse.

#12

Format of Payment Vouchers Under Medicare

From the Hudson County Medical Society

(Reference Committee "F")

Whereas, the Prudential Insurance Company has recently instituted a change in the format of payment vouchers for Medicare payments, with listing of payment for several patients on the same voucher; and

Whereas, this creates difficulty in submission of the "Explanation of Benefits" to New Jersey Blue Shield and other insurance companies for payment of the supplemental amounts due; and

Whereas, this creates other difficulties in filing of paid claims in the doctor's office; now therefore be it

RESOLVED, that the Prudential Insurance Company be requested to return to the former method of submitting individual "Explanation of Benefits" for each patient.

Foregoing "resolved" amended by the Reference Committee as follows (page Tr 134):

RESOLVED, that the Prudential Insurance Company be requested to improve methods for the submission of individual "Explanation of Benefits" data for each patient.

Adopted as amended by Reference Committee (page Tr 135)

#13

Better Protection of the Public from Eating Places Found Unsanitary

Henry A. Brodkin, M.D., Delegate, Essex County

(Reference Committee "G")

Whereas, after reporting that 80 per cent of the restaurants inspected throughout the State were satisfactory, the New Jersey State Department of Institutions and Agencies revised its health regulations to require that, after December 15, 1972, all restaurants post in a prominent place "their latest summary health inspection report and the three-page detailed report on request;" and

Whereas, in spite of the new regulations, the State Department of Health reported that — in the three-month period between December 15, 1972 and March 15, 1973—inspections disclosed that of 749 food establishments 351 were found satisfactory, 36 unsatisfactory, and 362 conditionally satisfactory—a circumstance which points up the weakness of the new system; and

Whereas, State and local health personnel have made adequate inspections and have instituted legal procedures against repeated violators of the health code, but, since little publicity has been given to violators, the public remains uninformed concerning unsatisfactory eating places; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey request

the Governor, the Legislature, and the State Department of Health to take steps to insure that all persistent violators of the health regulations be publicized in all news media, to alert and protect the public.

Reference Committee offered the following substitute resolution for Resolution #13. Substitute Resolution #13 adopted after amendment by the House by insertion of the words "to continue" after the word "Health" in the "resolved", to read: (page Tr 137)

Substitute Resolution #13

Better Protection of the Public from Food Handling Establishments Found Unsatisfactory

Whereas, Chapter 12 of the State Sanitory Code obliges all restaurants to post in a prominent place "their latest summary health inspection report and the three-page detailed report on request," and such posting has been found to be performed improperly; and

Whereas, although State and local health personnel have made adequate inspections and have instituted legal procedures against repeated violators of the health code, the public remains uninformed concerning unsatisfactory food handling establishments because little publicity has been given to violators; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey request the Governor, the Legislature, and the State Department of Health to continue to take steps to insure that all persistent violators of the health regulations be publicized in appropriate news media.



Retiring Executive Director and Mrs. Nevin



Newly appointed Executive Director and Mrs. Maressa

#14

Public Knowledge

From the Bergen County Medical Society

(Reference Committee "F")

Whereas, apparently, different insurance carriers have different schedules of "usual, customary, and reasonable" fees in each county, and only one such fee schedule can be accurate; and

Whereas, these fee schedules have been derived without proper consultation with representative physician groups in each county; and

Whereas, some fees for medical and surgical services are derived by methods which could be considered unreasonable, arbitrary, and capricious; and

Whereas, it is in the public interest that the finances of the health insurance carriers be open to public scrutiny; now therefore be it

RESOLVED, that the fee profile of reimbursement of the public or physician for medical services be public kuowledge; and be it further

RESOLVED, that the technique and means of creation of these schedules be public knowledge; and be it further

RESOLVED, that the books of all health insurance carriers be opened to public scrutiny upon demand; and be it further

RESOLVED, that the fee schedules be determined only after consultation with representative physician specialty groups at regional or county levels.

Reference Committee offered the fallowing substitute resalution for Resalutian #14 (Page Tr 135):

Substitute Resolution #14

Public Knawledge

Whereas, apparently, different insuronce corriers and third porty payors have different schedules of "usual, customary, and reosanable" fees in each county, and only ane such fee schedule con be accurate; and

Whereas, these fee schedules have been derived without proper consultation with representative physician groups in eoch county; and

Whereas, some fees for medical and surgical services are derived by methods which cauld be considered unreasonable, arbitrary, and copricious; and

Whereas, it is in the public interest thot the finances af the health insuronce corriers and third porty payars be apen to public scrutiny, now therefore be it

RESOLVED, that the third party payors' physicians fee profiles and reimbursement formulas be made public knowledge; and be it further

RESOLVED, thot the bases for the computation of these schedules be made public knowledge; and be it further

RESOLVED, thot third party payors' fee schedules be determined only after cansultatian with representative physician groups.

Hause vated to postpone indefinitely further discussion and refer both the original Resalution #14 and Substitute Resalutian #14 to the Council on Medical Services (page Tr 135)



House of Delegates in Session

#15

Health Insurance Carriers

From the Bergen County Medical Society
(Reference Committee "F")

Whereas, health insurance carriers have made statements to individual patients as to the indications for medical care and have implied overcharges for medical care and have interfered with the physician-patient relationship; now therefore be it

RESOLVED, that all health insurance carriers limit their relationship with patients strictly to payment for covered services rather than judgments on quality and need of medical care; and be it further

RESOLVED, that health insurance carriers be obligated to engage proper peer committees of each county medical society for each specialty to make any judgment of indications for medical care and quality of medical care; and be it further

RESOLVED, that health insurance carriers be obligated to make their complaints of misuse of insurance claims directly to the proper committee of each county medical society and to accept the decisions of these peer review committees as binding.

House voted to postpone indefinitely further discussion and refer both Resolution #15 and o Reference Committee proposed amendment to the Council on Medical Services (poge Tr 135)



(left) Dr. Harold A. Kaminetsky, Dean CMDNJ, New Jersey Medical College, accepts AMA-ERF check from President D'Elia



(right) Mr. Harold Logan, Associate Director, Community Health Allairs, CMDNJ, Rutgers Medical School, accepts AMA-ERF check from President D'Elia

#16

Blue Shield

From the Bergen County Medical Society

(Reference Committee "C")

Whereas, the Medical-Surgical Plan of New Jersey or "Blue Shield" has for many years advertised itself as "The Doctor's Plan"; and

Whereas, although The Medical Society of New Jersey approves selected representatives on the Board of Trustees of the Medical-Surgical Plan of New Jersey, these representatives do not have an effective voice in important policy matters of this insurance carrier; and

Whereas, this insurance carrier has interfered with the physician-patient relationship, has used misleading advertising, and does not clearly indicate that many of its insurancce policies are merely indemnity-type coverages; now therefore be it

RESOLVED, that the Medical-Surgical Plan of New Jersey or "Blue Shield" be enjoined from using the epithet "The Doctor's Plan"; and be it further

RESOLVED, that The Medical Society of New Jersey House of Delegates instruct its official medical representatives to the Board of Trustees of the Medical-Surgical Plan of New Jersey to vigorously pursue the aims and policies of The Medical Society of New Jersey and to properly report any actions of the carrier which are inimical to the doctor-patient relationship and good medical practice; and be it further

RESOLVED, that the fee schedules of Blue Shield be derived only after consultation with representative physician specialty groups at county and regional levels.

Rejected with notation (page Tr 130)

#17

Medicare Reimbursement Refusals

From the Bergen County Medical Society

(Reference Committee "F")

Whereas, in certain refusals of Medicare reimbursements to patients the Prudential Insurance Company of America states that the service was "not medically necessary" when, in fact, the service was consistent with good medical practice; and

Whereas, this phrase "not medically necessary" is used when reimbursement is not made for other reasons such as the service not being a prevailing one; and

Whereas, the Prudential Insurance Company explains the necessity of using this phrase as arising from the Medicare Law and its administration; and

Whereas, the effect of the use of this phrase

shifts the onus of non-payment from the Medicare program to the physician; and

Whereas, in many situations the use of this phrase injures the physician's integrity and reputation in the eyes of the patient and thus interferes with the trust that this relationship depends upon; and

Whereas, future cutbacks in the Medicare program may be conveniently blamed upon physicians instead of the program itself; now therefore be it

RESOLVED, that The Medical Society of New Jersey actively seek to have the Social Security Administration notify the patient of the exact reason for denial of claim; and be it further

Foregoing "resolved" amended by Reference Committee by deleting the words "Social Security Administration" and substituting the words "Prudential Insurance Company of America." (page Tr 135)

RESOLVED, that The Medical Society of New Jersey communicate its concern in this issue to the American Medical Association and to the senior citizens organizations.

Foregoing "resolved" amended by Reference Committee by deleting the words "and to the senior citizens organizations." (page Tr 135)

Adopted as amended by Reference Committee (page Tr 135)



Drs. Joseph R. Jehl, John P. Kengeter, James E. D. Gardam and Edward Foord

#18

Fitness for Licensure

From the Bergen County Medical Society
(Reference Committee "F")

Whereas, conflicting opinions have been expressed concerning criteria for summoning a physician before the State Board of Medical Examiners to determine his fitness to remain licensed in New Jersey; now therefore be it

RESOLVED, that the House of Delegates respectfully request the Board of Trustees of The Medical Society of New Jersey to investigate and clarify regulations and conditions under which a physician may be called for a hearing concerning his license to practice medicine and surgery in the State of New Jersey.

Adopted (page Tr 135)

#19

Chronic Alcoholism

From the Bergen County Medical Society

(Reference Committee "F")

Whereas, the incidence of Jellinek's Disease (Chronic Alcoholism) in the United States is constantly increasing; and

Whereas, the number of afflicted alcoholics in need of in-patient hospital care is also increasing; and

Whereas, in many of our hospitals existing policies with regard to the admission of these patients are restrictive or exclusive; and

Whereas, it has been established that in-patient alcoholics do not unduly disrupt normal hospital routines and can easily be managed in a general ward of service; now therefore be it

RESOLVED, that The Medical Society of New Jersey recommend to all hospitals that they review their admission policies for alcoholics and liberalize them if necessary; and be it further

RESOLVED, that The Medical Society of New Jersey urge all physicians to abstain from using names of other pathological conditions in place of the diagnosis of "alcoholism", which has sometimes been done in the past.

Reference Committee offered the following substitute resolution for Resolution #19; Substitute Resolution #19 Adopted (page Tr 135)

Substitute Resolution #19

Chronic Alcoholism

Whereas, the incidence of Chronic Alcoholism in the United States is constantly increasing; and

Whereas, the number of afflicted alcoholics in need of in-patient hospital care is also increasing; and

Whereas, in many of our hospitals existing policies with regard to the admission of these patients are restrictive or exclusive; and

Whereas, it has been established that in-patient alcoholics do not unduly disrupt normal hospital routines and can easily be managed in a general ward of services; now therefore be it.

RESOLVED, that The Medical Society of New Jersey recommend to all hospitals that they review their admission policies for alcoholics and, if necessary, liberalize them to admit alcoholics; and be it further

RESOLVED, that The Medical Society of New Jersey urge all physicians to abstain from using names of other pathological conditions in place of the diagnosis of "alcoholism," when alcoholism is the primary manifesting problem; and be it further

RESOLVED, that this resolution be presented to the House of Delegates of the AMA at the next annual meeting.



Incoming President, Dr. Boylan, AMA Trustee, Dr. Holden, Fellow, Dr. Satulsky

#20

Fee Dispute Committee

From the Bergen County Medical Society

(Reference Committee "A")

Whereas, the judicial mechanism is primarily concerned with problems of ethical conduct; and

Whereas, fee disputes may or may not involve breaches of ethics; and

Whereas, the judicial mechanism functions more effectively and efficiently if problems relating purely to fee structure and not involving medical ethics are properly delegated; and

Whereas, some county peer review committees now functioning are multiple, with purposes at times not clearly defined and occasionally overlapping; now therefore be it

RESOLVED, that fee disputes may be delegated by the county judicial committee to other appropriate peer review committees; and be it further

RESOLVED, that fee disputes must well be the ultimate responsibility of the county judicial committees and the State Judicial Council.

Rejected with notation (page Tr 127)

#21

Control of the Sale of Certain Drugs

From the Bergen County Medical Society

(Reference Committee "F")

Whereas, potentially dangerous and habit forming drugs such as barbiturates, belladonna and its extractives, ephedrine products, vasopressors, antihistamines, bromides, alcoholic solutions over 10% and opium derivatives are available for purchase unsupervised by pharmacists and without prescriptions in a large variety of retail establishments; and

Whereas, the New Jersey State Board of Pharmacy has indicated its intention to establish a new class of drugs to be sold only under licensed pharmaceutical supervision including many of the above-mentioned medicinals (N.J. Adm. Code Section 13:39-9-13); and

Whereas, the New Jersey Allergy Society has gone on record as supporting the proposal of the New Jersey State Board of Pharmacy to establish a new class of drugs as indicated, and to require that the drugs specified be dispensed only by pharmacists and on the prescription of duly licensed physicians; now therefore be it

RESOLVED, that The Medical Society of New Jersey go on record as officially adopting the same position taken by the New Jersey Allergy Society; and be it further

RESOLVED, that the action of The Medical Society of New Jersey be reported to the New Jersey State Board of Pharmacy and to the State Department of Health.

Rejected with notation (page Tr 136)

#22

Equitable Composition of FDA Panel on Drug Evaluations

From the Bergen County Medical Society
(Reference Committee "F")

Whereas, a new federal administrative fiat now mandates that the United States Food and Drug Administration re-evaluate not only the safety but also the efficacy of all drugs and medicinals now used in medical and surgical practice; and

Whereas, the Food and Drug Administration by this administrative edict will affect profoundly the means available to physicians to practice medicine and surgery in all specialties; and

Whereas, the Food and Drug Administration Bureau of Biologicals has, in February 1973, announced its panel for evaluation of drugs and biologicals and antigens used by allergists and this panel includes only one allergist who is primarily practice-oriented; and

Whereas, all drugs could eventually be so evaluated by similar panels of academically rather than clinically practice-oriented physicians, now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey go on record requesting the United States Food and Drug Administration and its various divisions to evaluate all drugs by well-balanced panels of equally highly qualified practicing physicians as well as academically and research-oriented physicians; and be it further

RESOLVED, that this House of Delegates direct our Society's Delegation to the American Medical Association to seek the support of the American Medical Association in a concerted effort to prevail upon the Food and Drug Administration to use a well-balanced panel consisting of practicing physicians and research-oriented physicians in its evaluation of all drugs and biologicals as to their efficacy and safety.

Adopted **(page Tr 136)**



Dr. Leo H. Siegel, President Academy of Medicine of New Jersey accepts MSNJ's contribution to the Academy from President D'Elia

#23

Establishment of a Physicians' Guild

From Kurt Manrodt, M.D., Delegate, Passaic County
(Reference Committee "A")

Whereas, it is becoming increasingly apparent that an effective mechanism of dealing with third party problems is necessary; and

Whereas, the sentiment of the membership of The Medical Society of New Jersey was secured by a ballot in 1972, having a reply of 31.7% and expressing a majority vote of approval of 1,696 to 893; and

Whereas, the guild concept would appear to be an acceptable, dignified, and effective mechanism for handling some of the socio-economic problems of The Medical Society of New Jersey; now therefore be it

RESOLVED, that The Medical Society of New Jersey permit and endorse the concept of the formation of a physician's guild as a coexisting and cooperating organization.

Rejected with notation (page Tr 127)

#24

Compulsory Mediation in Malpractice Suits

From the Union County Medical Society
(Reference Committee "C")

Whereas, the practicing physicians of New Jersey are increasingly confronted with lawsuits for reasons of real or alleged malpractice; and

Whereas, the system of voluntary mediation adopted by the Supreme Court of New Jersey in February of 1966 has steadily declined in effectiveness since its inception to a point now where it is scarcely being utilized at all; and

Whereas, New York County has apparently benefited from the adoption of an initial compulsory mediation promulgated by the Supreme Court of the State of New York; and

Whereas, a current analysis of actual cases mediated there attests to the fact that out of a total of 230 cases 29 per cent of 58 were settled by the panel by mutual agreement between litigants without further judicial action; and

Whereas, it is the opinion of the joint interprofessional committee in New York that with some improvements in procedure the current rate of 29 per cent could be bettered; now therefore be it

RESOLVED, that The Medical Society of New Jersey recommend to the Supreme Court of New Jersey that initially, compulsory mediation be made a part of the judicial process in malpractice suits; and be it further

RESOLVED, that the panel be composed of three persons—a judge, a physician, who is an expert in the specialty of medicine involved in the case, and an attorney whose expertise lies in the area of litigation.

Withdrawn by the sponsor

#25

Medicaid Waiver Project

A. E. Bythewood, M.D., Delegate, Essex County

(Reference Committee "F")

Whereas, the purpose of the Medicaid Waiver Project to provide funds for the working poor is of excellent intent; and

Whereas, a Health Care Plan must be equitable, accessible, and acceptable for all citizens, including the working poor; and

Whereas, the Plan, as presently constituted, deprives the patient of free choice of physician and hospital; and

Whereas, the American system has always protected this right of free choice; and

Whereas, the patient must be given his free choice of physician, clinic, or hospital under this project; and

Whereas, this Plan offers no fiscal guarantees to improve the delivery of health care in the City of Newark; and

Whereas, this Plan excludes two Newark hospitals serving important areas of the city; and

Whereas, this Plan has been designated as a pilot project for other communities throughout the State and Nation; and

Whereas, the planning of any health care system must include input from all segments of the health care professions and the consumers of such health care; now therefore be it

RESOLVED, that The Medical Society of New Jersey go on record as being opposed to this Plan as now outlined; and be it further

RESOLVED, that this Plan not be implemented as presently constituted; and be it further

RESOLVED, that an immediate meeting be called of directly involved consumers, physicians, hospitals, and the State Department of Health to plan appropriate changes to provide excellent care with free choice of physician, clinic, and/or hospital; and be it further

RESOLVED, that The Medical Society of New Jersey immediately forward copies of this resolution to Governor William T. Cahill, and Commissioner of Health James R. Cowan, M.D.

With the concurrence of the Reference Committee, the Essex County Medical Society offered the following Substitute Resolution #25, which embodied an amendment suggested by the Reference Committee. Substitute Resolution #25 Adopted (page Tr 136)

Substitute Resolution #25

Medicaid Waiver Project

Whereas, the purpose of the Medicaid Waiver Project is of excellent intent; and The Medical Society of New Jersey supports this additional allocation of funds to the working poor; and

Whereas, a Health Care Plan must be equitable, accessible, and acceptable for all citizens, including the working poor; and

Whereas, the Plan, as presently constituted, deprives the patient of free choice of physician and hospital; and

Whereas, the American system has always protected this right of free choice, as does the present Medicaid plan; and

Whereas, the patient must be given his free choice of physician, clinic, or hospital under this project; and

Whereas, this Plan offers no fiscal guarantees to improve the delivery of health care in the City of Newark; and

Whereas, this Plan, as presently constituted, excludes two Newark Hospitals serving important areas of the city; and

Whereas, this Plan has been designated as a pilot project for other communities throughout the State and Nation; and

Whereas, the planning of this health care system must include input from all segments of the health care professions and the consumers of such health care; now therefore be it

RESOLVED, that The Medical Society of New Jersey go on record as being opposed to this Plan as now outlined; and be it further

RESOLVED, that this Plan not be implemented as presently constituted; and be it further

RESOLVED, that an immediate meeting be called of directly involved consumers, physicians, dentists, hospitals, the State Department of Health, the Department of Institutions and Agencies, and other providers of health services to plan apropriate changes to provide excellent care with free choice of physician, clinic, and/or hospital; and be it further

RESOLVED, that the Newark Comprehensive Health Services Plan Advisory Board be enlarged by representatives of the Community and of the providers of health care; and be it further

RESOLVED, that The Medical Society of New Jersey immediately forward copies of this resolution to Governor William T. Cahill and Commissioner of Health James R. Cowan, M.D., R. L. Clifford, Commissioner, Department of Institutions and Agencies, and William Dougherty, M.D., Medicaid Waiver Project, New Jersey Department of Health.

#26

Nonsupport of New Jersey Foundation for Health Care Evaluation

Peter A. Mele, M.D., Delegate, Bergen County

(Reference Committee "B")

Whereas, the belated report of the functions and goals of the New Jersey Foundation for Health Care Evaluation has only recently been presented to the Bergen County Medical Society; now therefore be it

RESOLVED, that the Bergen County Medical Society withdraw its support of the New Jersey Foundation for Health Care Evaluation; and be it further

RESOLVED, that the Bergen County Medical Society strongly urges that its members do not support the recommended special assessment to be adopted at $10.00 per capita for the Foundation; and be it further

RESOLVED, that the Bergen County Medical Society present this resolution to the House of Delegates of The Medical Society of New Jersey at the May 1973 meeting for the support and action of the House of Delegates in disapproving the support of the New Jersey Foundation for Health Care Evaluation.

Rejected with notation (poge Tr 129)

#27

Financial Support for the New Jersey Foundation for Health Care Evaluation

John J. Reilly, Jr., M.D., Delegate, Union County

(Reference Committee "B")

Whereas, just recently, the ultimate goals and aims of the New Jersey Foundation for Health Care Evaluation were published in The Medical Society of New Jersey *Membership Newsletter; and*

Whereas, the specific goals and functions of the Foundation are not as yet clearly defined, and some of these functions may not be in the best interests of the practicing physician; and

Whereas, this Foundation to date has already been funded through our dues at the rate of $6,000 per month; and

Whereas, recommendation for a special assessment to fund this Foundation is currently under consideration at this meeting; now therefore be it

RESOLVED, that this House of Delegates withdraw its financial support and defeat the proposal for a special assessment for this Foundation.

Rejected with notation (poge Tr 129)

#28

Opposition to Third Party Carriers Serving as Fee Arbiters

Donald J. Holtzman, M.D., Delegate, Union County
(Reference Committee "C")

Whereas, the Aetna Insurance Company has during the recent past proved itself to be opposed to the generally accepted patient-physician relationship by dint of its so-called "hold harmless clause"; and

Whereas, it has on many occasions implied to patients in communications in regard to settlement of fee obligations that they are the arbiter of fee adequacy; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey direct the State Medical Society to disassociate itself from sponsorship of insurance plans proposed by Aetna Insurance Company, such as the recent automobile insurance coverage through the E. & W. Blanksteen Agency.

Foregoing "resolved" amended by the House as follows (page Tr 130):

RESOLVED, that Aetna Insurance Company be informed of our displeasure with their actions; and be it further

RESOLVED, that the House of Delegates of The Medical Society of New Jersey direct the State Medical Society to re-evaluate its position with the possibility of disassociating itself from sponsorship of insurance plans proposed by Aetna; and be further

RESOLVED, that investigation of similar coverage with competitive carriers be continued.

Adopted as amended by the House (page Tr 130)



Mr. Nevin accepts citation from President D'Elia at second session of the House.

#29

Investigation of "Medical Centers" or "Health Centers"

From the Passaic County Medical Society

(Reference Committee "A")

Whereas, there is a growing number of so-called "Medical Centers" or "Health Centers" in Passaic County and throughout the State; and

Whereas, these centers are in many cases commercial ventures operating in violation of state law and medical ethics; and

Whereas, these centers cannot be controlled by a county medical society for lack of investigatory facilities, and because physicians practicing in these centers are frequently not members of the local county medical society; and

Whereas, there is increasing evidence that the public is being exploited and abused by the practices and policies of these centers; now therefore be it

RESOLVED, that the Judicial Council of The Medical Society of New Jersey review the activities of its members in these so-called "Medical Centers" or "Health Centers" to determine if such activities meet the norms of ethical medical conduct; and be it further

RESOLVED, that the State Board of Medical Examiners of New Jersey investigate these so-called "Medical Centers" or "Health Centers" to determine whether they are operating within legal parameters as set forth in the Medical Practice Act of New Jersey.

Reference Committee offered the following substitute resolution for Resolution #29. Substitute Resolution #29 Adopted (page Tr 127)

Substitute Resolution #29
Investigation of "Medical Centers" or "Health Centers"

Whereas, there is a growing number of store-front, self-styled, "Medical Centers" or "Health Centers" in Passaic County and throughout the State; and

Whereas, these establishments are in many cases commercial ventures operating in violation of state law and medical ethics; and

Whereas, these establishments cannot be controlled by a county medical society because of lack of investigatory facilities, and because physicians practicing in these establishments are for the most part not members of the local county medical society; and

Whereas, there is increasing evidence that the public is being exploited and abused by the practices and policies of these establishments; now therefore be it

RESOLVED, that the Judicial Council of The Medical Society of New Jersey review the activities of the Society's members in these self-styled "Medical Centers" or "Health Centers" to determine if such activities meet the norms of ethical medical conduct; and be it further

RESOLVED, that the State Board of Medical Examiners of New Jersey investigate these self-styled "Medical Centers" or "Health Centers" to determine whether they are operating within legal parameters as set forth in the Medical Practice Act of New Jersey.



House of Delegates—Third Session

REFERENCE COMMITTEES

Reference Committee on Constitution and Bylaws

Raymond A. McCormack, Jr., M.D., Chairman

Reference Committee on Constitution and Bylaws met on Saturday, May 12, 1973, with all members present: Doctors Merton L. Griswold, Jr., Gastone A. Milano, Charles I. Nadel, E. Spencer Paisley, and the chairman. Approximately 25 delegates and members were present to discuss the various items under consideration.

1. **Revision of Constitution and Bylaws** (page Tr 51)

a. **Proposed Amendment to the Constitution**—Affiliate Membership (page Tr 51)

The Committee **recommends** that the report be adopted.

Adopted

b. **Proposed Amendment to the Bylaws**—Continuing Medical Education (page Tr 51)

The Committee **recommends** that the report be adopted.

Amended by the House by deletion of the word "sotisfactorily" in the second sentence of the proposed amendment to the Bylaws.

Adopted as amended by the House

c. **Proposed Amendment to the Bylaws**—AMA Delegates (page Tr 52)

The Committee **recommends** that the report be adopted.

Adopted

d. **Proposed Amendment to the Bylaws**—Membership for Interns and Residents (page Tr 53)

The Committee **recommends** that the report be adopted.

Adopted

Resolution:

Robert's Rules of Order—Resolution #1 (page Tr 104)

In discussing Resolution #1, it was pointed out that Sturgis' "Standard Code of Parliamentary Procedure" is less complex and more efficacious and that, as the membership becomes more familiar with the Code, the business of the House will be dispatched more smoothly.

The Committee **recommends** that Resolution #1 be rejected.

Adopted



House of Delegates—Third Session

Reference Committee "A"

Donald T. Akey, M.D., Chairman

Reference Committee "A" met on Saturday, May 12, 1973, with all members present: Doctors Meyer L. Abrams, Dexter B. Blake, Warren E. Crane, Thomas F. Reilly, and the chairman. Approximately 33 delegates and members were present to discuss the various items under consideration.

1. **President** (page Tr 5)

The Committee **recommends** that the report be filed.

Amended by the House to include the statement that this House of Delegates appreciates the devoted and outstanding services of the President and commends and congratulates him on the exemplary performances of his multitudinous duties.

Adopted with commendation

2. **Board of Trustees** (page Tr 15)

The introductory portion of this report, covering the general activities of the Board, was reviewed and approved.

The Committee **recommends** that this portion of the report be filed.

Adopted

a. **Ad Hoc Committee to Investigate the Nominating Procedure** (page Tr 15)

The Committee **recommends** that the recommendations on pages Tr 16-17 of the annual report be approved.

Adopted with the following notation concerning the third recommendation: That it is the consensus of the House of Delegates that the County Societies should have the prerogative to name and send as a nominating delegate whomever they shall choose and for as many terms as they shall choose.

The Committee **recommends** that the report be filed.

Adopted

b. **Joint Conference of Presidents and Presidents-Elect of Component Societies** (page Tr 17)

The Committee **recommends** that the report be filed.

Adopted

c. **Joint Practice Committee with the New Jersey State Nurses' Association** (page Tr 17)

The Committee **recommends** that the report be filed.

Adopted

d. **Liberalization of Abortion Laws** (page Tr 18)

The Committee **recommends** that the report be filed.

Adopted

e. **Special Session of the House of Delegates** (page Tr 18)

The Committee **recommends** that the report be filed.

Adopted

f. **Survey of Methods to Increase AMA Membership** (page Tr 20)

The Committee **recommends** that the report be filed.

Adopted

g. **New Jersey Health Care Council** (page Tr 24)

The Committee **recommends** that the report be filed.

Adopted

3. **Secretary** (page Tr 7)

The Committee **recommends** that the report be filed.

Adopted

4. **Judicial Council** (page Tr 26)

The Committee **recommends** that the report be filed.

Adopted

5. **Executive Director** (page Tr 28)

The Committee **recommends** that the report be filed.

Adopted

6. **Credentials** (page Tr 34)

The Committee **recommends** that the report be filed.

Adopted

7. Resolutions:

a. **Establishment of a School of Physical Therapy in New Jersey**—Resolution #2 (page Tr 104)

In discussing Resolution #2, the sponsor of the resolution suggested that the third and fourth "Whereas" be deleted. The Committee so **recommends.**

Adopted

The Committee **recommends** that Resolution #2 be adopted as amended.

Adopted as amended by Reference Committee

b. **Fee Dispute Committee**—Resolution #20 (page Tr 118)

The Committee noted that the Bylaws assign exclusive responsibility to the Judicial Mechanism in fee disputes. The Committee also noted that by the simple expedient of increasing county judicial committee membership, a greater case load could be handled satisfactorily, with preservation of confidentiality and the mechanism of appeal.

The Committee **recommends** that Resolution #20 be rejected.

Adopted

c. **Establishment of a Physicians' Guild** — Resolution #23 (page Tr 120)

In view of the action taken at the Special Session of the House of Delegates held in December 1972, the Committee **recommends** that Resolution #23 be rejected.

Adopted

d. **Investigation of "Medical Centers" or "Health Centers"**—Resolution #29 (page Tr 124)

The Committee **recommends** that the following **Substitute** Resolution #29 be adopted.

(Underscoring indicates proposed amendments)

Whereas, there is a growing number of store-front, self-styled, "Medical Centers" or "Health Centers" in Passaic County and throughout the State; and

Whereas, these establishments are in many cases commercial ventures operating in violation of state law and medical ethics; and

Whereas, these establishments cannot be controlled by a county medical society because of lack of investigatory facilities, and because physicians practicing in these establishments are for the most part not members of the local county medical society; and

Whereas, there is increasing evidence that the public is being exploited and abused by the practices and policies of these establishments; now therefore be it

RESOLVED, that the Judicial Council of The Medical Society of New Jersey review the activities of the Society's members in these self-styled "Medical Centers" or "Health Centers" to determine if such activities meet the norms of ethical medical conduct; and be it further

RESOLVED, that the State Board of Medical Examiners of New Jersey investigate these self-styled 'Medical Centers" or "Health Centers" to determine whether they are operating within legal parameters as set forth in the Medical Practice Act of New Jersey.

Upon motion the House agreed to consider substitute Resolution #29

Substitute Resolution #29 Adopted



Auxiliary President, Mrs. Edward Gandek, reports to House of Delegates

Reference Committee "B"

Francis A. Pflum, M.D., Chairman

Reference Committee "B" met on Saturday, May 12, 1973, with all members present: Doctors Frank M. Galioto, Charles Krueger, Daniel J. O'Regan, Elbert H. Pogue, and the chairman. Approximately 70 delegates and members were present to discuss the various items under consideration. About 15 members spoke, including guest speaker, Raymond T. Holden, M.D., from the AMA.

1. **Treasurer** (page Tr 8)

The Committee gives special recognition to the Treasurer for his efforts and **recommends** that the report be filed.

Adopted

2. **Finance and Budget** (page Tr 35)

The Committee **recommends** that the recommendations on pages 36-37 of the annual report be approved. However, the Committee questions the procedure of allocating funds for the Academy of Medicine *via* the Committee on Medical Education. The Committee again urges MSNJ to re-evaluate its relationship to the Academy of Medicine relative to the contribution of further funds for the 1973-1974 year and thereafter.

a. Budget for 1973-1974 of $558,989.

Adopted

b. Per capita assessment for 1974 at $90.

Adopted

c. Funds for Academy of Medicine provided in budget allocation to Committee on Medical Education.

Adopted

d. Designation of $3.50 and $2.50 respectively for *Journal* subscription and annual meeting registration.

Adopted

e. One-time, $10 per capita, grant to New Jersey Foundation for Health Care Evaluation.

Adopted

f. Affiliate and associate assessment set at $20.

Adopted

The Committee **recommends** that the report be filed.

Adopted

3. **Medical Student Loan Fund** (page Tr 47)

The Committee notes with satisfaction the increase from 12 to 30 applications during the 1972-1973 administrative year and the added benefits to the citizens of the State of New Jersey resulting therefrom.

Your Reference Committee especially commends the Essex County Medical Society for its generous gift of $10,000 to the Fund this year, and expresses the hope that other component societies may be moved to emulation.

The Committee **recommends** that the report be filed.

Adopted with approval of the contained recommendations.

4. **Physicians' Relief Fund** (page Tr 84)

The Committee **recommends** that the report be filed.

Adopted

5. **Publication** (page Tr 50)

The Committee notes and supports the plea for younger physicians qualified to serve as associate editors of *The Journal.*

The Committee **recommends** that the report be filed.

Adopted

6. **Project Hope/Vietnam** (page Tr 84)

The Committee, recognizing that there was no activity whatsoever in connection with

this Committee, **recommends** that the report be filed.

Adopted

7. **Resolutions:**

a. **Nonsupport of New Jersey Foundation for Health Care Evaluation**—Resolution #26 (page Tr 122)

b. **Financial Support for the New Jersey Foundation for Health Care Evaluation** — Resolution #27 (page Tr 122)

Resolutions #26 and #27 were considered together, since basically they reflect similar thinking.

After much discussion, and a number of speakers pro and con—including some pertinent remarks from Dr. Holden of the AMA —the Committee finally decided that, since they had already indicated approval of the report of the Committee on Finance and Budget, in order to be consistent, there was no alternative but to **recommend** that Resolutions #26 and #27 be rejected.

Adopted

Reference Committee "C"

Edward A. Schauer, M.D., Chairman

Reference Committee "C" met on Sunday, May 13, 1973, with all members present: Doctors Donald P. Burt, Karl T. Franzoni, Warren Knauer, Roy A. Morrow, and the chairman. Approximately 84 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees—Item**

MSP Board of Trustees—Nominations—Supplemental (page Tr 24)

The Committee **recommends** that the report be approved.

Adopted

2. **Medical-Surgical Plan of New Jersey** (page Tr 87) and Supplemental (page Tr 97)

The Committee considered the printed booklet and the supplemental report separately. The Committee would like to commend Doctor Donnelly and the Medical-Surgical Plan for its review of the last 30 years and an excellent report. Many questions about the Medical-Surgical Plan were answered in the reference committee.

The Committee **recommends** that the reports be filed.

Adopted

3. **Medical Defense and Insurance** (page Tr 40)

The Reference Committee considered the report of the Committee on Medical Defense and Insurance. Doctor Paul Kreutz, Mr. David Blanksteen, and Mr. Joseph Britton were in attendance to answer questions and to supply further information.

The Committee **recommends** that the recommendations on pages Tr 43 and Tr 45 of the annual report be approved.

Adopted

The Committee **recommends** that the report be filed.

Adopted

4. **Retirement Plan for Physicians** (page Tr 85)

The Reference Committee took note of the three unique advantages in the Retirement Investment Plan of the State as listed on page Tr 85 of the annual report.

The Committee **recommends** that the report be filed.

Adopted

5. **Resolutions:**

a. **Blue Shield**—Resolution #16 (page Tr 115)

The Reference Committee considered Resolution #16 on "Blue Shield," presented by the Bergen County Medical Society.

There was a great deal of discussion, including testimony from members who currently serve on the Board of the Medical-Surgical Plan, refuting the second "Whereas" and questioning the need for the third "Resolved". In addition, there was legal opinion presented that the second "Resolved" embodies a conflict of interest situation.

After due consideration, the Committee **recommends** that Resolution #16 be rejected.

Adopted

b. **Opposition to Third Party Carriers Serving as Fee Arbiters**—Resolution #28 (page Tr 123)

The Reference Committee considered Resolution #28, "Opposition to Third Party Carriers Serving as Fee Arbiters," presented by the Union County Medical Society.

There was considerable discussion, including testimony from Mr. Blanksteen, concerning the automobile insurance coverage offered by the Society. While the Reference Committee is in accord with the intent of this resolution with reference to third party carriers serving as fee arbiters, the Committee feels that this problem should be vigorously objected to and opposed separately; because of this, however, another service to certain members of MSNJ should not be arbitrarily withdrawn. The "Resolved" portion of this resolution calls for this action.

Therefore, although we are not against the opposition mentioned in the heading of the resolution, we cannot endorse this resolution because of its requested action.

The Committee **recommends** that Resolution #28 be rejected.

Not Adopted

The House amended the resolved section of Resolution #28 as follows:

RESOLVED that Aetna Insurance Company be informed of our displeasure with their actions; and be it further

RESOLVED, that the House of Delegates of The Medical Society of New Jersey direct the State Medical Society to re-evaluate its position with the possibility of disassociating itself from sponsorship of insurance plans proposed by Aetna; and be it further

RESOLVED, that investigation of similar coverage with competitive carriers be continued.

Adopted as amended.

We wish to thank all of those who attended the Reference Committee for their thoughts and contributions, and I wish to thank all of the members of the Committee for their kind assistance.



Mr. Nevin acknowledges ovation from the House on his appointment as Executive Director Emeritus President-Elect Rogers and then President D'Elia in the background.

Reference Committee "D"

William A. Dwyer, Jr., M.D., Chairman

Reference Committee "D" met on Saturday, May 12, 1973, with the following members present: Doctors John F. Marshall, Paul H. Pettit, and the chairman. Approximately 41 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees—Item**

Licensure by Endorsement for Diplomates of Specialty Boards (page Tr 20)

The Committee **recommends** that the report be filed.

Adopted

2. **Medical Education** (page Tr 46)

The Committee **recommends** that the report be filed.

Adopted

3. **Emergency Medical Care** (page Tr 82)

This report engendered considerable discussion particularly in reference to the section dealing with the training of emergency medical technicians for emergency department use. Concern was expressed by some that the Nursing Practice Act does not allow those potential EMT's to function at the level of their training.

The section on the establishment of an emergency medical care center at the Newark Airport also precipitated some discussion, and no one was able to elucidate its exact intent. As far as those present were able to ascertain, Newark Airport now has a dispensary with physician and nurse coverage for ordinary emergencies and is developing a well-integrated disaster plan for large-scale emergencies. Therefore, the Committee felt that this portion of the report was not necessary.

The Committee **recommends** that the recommendation on page Tr 83 of the annual report be approved.

Adopted

The Committee **recommends** that the report be filed.

Adopted

4. **Medicine and Religion** (page Tr 84)

The Committee **recommends** that the report be filed.

Adopted

5. **Resolutions:**

a. **Establishment of a Mechanism to Coordinate Postgraduate Medical Educational Programs**—Resolution #3 (page Tr 105)

This resolution intends that The Medical Society of New Jersey establish a statewide mechanism for clearance of topic, date, and geographic area to avoid duplication of effort in postgraduate medical education.

It was apparent to the Committee that Doctor Rogers' medical education program is already serving or shortly will serve this function. Therefore this resolution is unnecessary.

The Committee **recommends** that Resolution #3 be rejected.

Adopted

b. **Support of Interagency Commission on Emergency Medical Care** — Resolution #4 (page Tr 106)

This resolution is intended to help preserve yet another coordinating mechanism, this in the field of emergency medicine.

While the Committee felt that the intent of the resolution was commendable, the lack of indication as to what constituted "sound financial assistance" made us hesitate.

The Committee **recommends** that Resolution #4 be adopted, as amended as follows:

RESOLVED, that MSNJ continue to support the efforts of the Interagency Commission, including financial assistance approved by the

Board of Trustees up to $2500 for one year, and that it encourage other participating agencies to contribute to the support of this agency as well.

Upon motion the House agreed to consider amended Resolution #4.

Adopted as amended by the Reference Committee.

Reference Committee "E"

Arthur Bernstein, M.D., Chairman

Reference Committee "E" met on Sunday, May 13, 1973, with all members present: Doctors David R. Brewer, Jr., Vincent H. Gillson, Bernard D. Pinck, Charles O. Tyler, and the chairman. Approximately 35 delegates and members were present to discuss the various items under consideration.

1. **Legislation** (page Tr 55) and **Supplemental** (page Tr 63)

The Committee **recommends** that Senate Bill 1041 be referred back to the Council on Legislation for reconsideration.

House amended Reference Committee recommendation by directing that, in addition, S-852 and A-836, and S-1054 be referred back to the Council on Legislation for reconsideration.

Adopted as amended by the House.

The Committee **recommends** that the report be filed.

Adopted

2. **Public Relations** (page Tr 79)

The Committee **recommends** that the report be filed.

Adopted

3. **Resolutions:**

a. **Death Certificate Law** — Resolution #5 (page Tr 106)

The Committee **recommends** that Resolution #5 be rejected.

Adopted

b. **Medical Testimony**—Resolution #11 (page Tr 110)

The Committee **recommends** that the following Substitute Resolution #11 be adopted.

Whereas, drug abuse control statutes of the State of New Jersey provide for the prosecution of persons who are in violation of those statutes; and

Whereas, medical testimony is often requisite in the establishment of evidence of such abuse; and

Whereas, organized medicine should play an active part in assisting in the litigation of such cases; now therefore be it

RESOLVED, that The Medical Society of New Jersey develop a list of medical experts to be available for the purpose of providing medical testimony in cases dealing with drug abuse.

Upon motion the House agreed to consider Substitute Resolution #11

Substitute Resolution #11 Adopted

The Committee commends both the Council on Public Relations and the Council on Legislation for their fine work.

Reference Committee "F"

Hillel M. Ben-Asher, M.D., Chairman

Reference Committee "F" met on Sunday, May 13, 1973, with all members present: Doctors Rudolph T. DePersia, John P. Kengeter, Frederick J. Knoeke, Josiah C. McCraeken, Jr., and the chairman. Approximately 40 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees—Items**

a. **Alcoholism Detection and Prevention Clinics** (page Tr 22)

It was noted that MSNJ's position was diluted by the AMA House of Delegates in that the resolution adopted by the AMA emphasizes the non-medical components of the treatment of alcoholism.

The committee **recommends** that the report be filed.

Adopted

b. **Drug Abuse Registry** (page Tr 20)

The committee **recommends** that the report be filed.

Adopted

c. **Establishment of a Membership Inquiry and Complain Mechanism** (page Tr 21)

The Committee **recommends** that the report be filed.

Adopted

d. **Improper Denial of Physicians' Claims Under Medicaid** (page Tr 21)

The Committee **recommends** that the report be filed.

Adopted

e. **Pilot Pediatric Nurse Practitioner Program in New Jersey** (page Tr 22)

The committee **recommends** that the report be filed.

Adopted

f. **Separate Department of Mental Health** (page Tr 22)

The Committee **recommends** that the report be filed.

Adopted

g. **Training Center for Drug Abuse Prevention and Treatment** (page Tr 22)

The Committee **recommends** that the report be filed.

Adopted

h. **Uniform Procedural Terminology Project** —Supplemental (page Tr 24)

The Committee **recommends** that the report be filed.

Adopted

2. **Medical Services** (page Tr 66)

The Committee **recommends** that the report be filed.

Adopted

3. **Occupational Health, Workmen's Compensation, and Rehabilitation** (page Tr 68)

The Committee **recommends** that the report be filed.

Adopted

4. **Mental Health** (page Tr 69)

Concerning the third paragraph of this report, the Committee is pleased to note that a member of MSNJ specializing in psychiatry has been appointed Director of Mental Health and Hospitals for the State of New Jersey.

The Committee **recommends** that the report be filed.

Adopted

5. **Alcoholism** (page Tr 70)

The Committee **recommends** that the report be filed.

Adopted

6. **Drug Abuse** (page Tr 71)

The Committee **recommends** that the report

be filed.

Adopted

7. **Emotional Disorders of Childhood and Adolescence** (page Tr 73)

The Committee **recommends** that the report be filed.

Adopted

8. **Mental Retardation** (page Tr 73)

The Committee **recommends** that the report be filed.

Adopted

9. **Neurological and Related Disorders** (Tr 74)

The Committee **recommends** that the report be filed.

Adopted

10. **Resolutions:**

a. **Medicaid Payments to Clinics and Physicians**—Resolution #6 (page Tr 107)

The Committee **recommends** that the following substitute Resolution #6 be adopted.

Whereas, Medicaid is paying clinics at a much higher rate per visit than it is paying private physicians for similar services; and

Whereas, the total cost to the State for Medicaid care in clinics is greater than the total cost in private physicians' offices; and

Whereas, private physicians are required to pay all taxes and office overhead expenses; and

Whereas, services of private physicians are generally more efficient and more readily available, as opposed to the limited service hours in public clinics; and

Whereas, the private physician is the foundation of the continuity of medical care; and

Whereas, the Medicaid Program is in effect defeating its intent of providing equal care to all patients and is limiting the patients' free choice of physicians; now therefore be it

RESOLVED, that The Medical Society of New Jersey do all in its power to rectify this Medicaid inequity and to bring the payments for services rendered more in line with realistic values; and be it further

RESOLVED, that, concerning this matter, the Council on Medical Services be instructed to consult with the proper State authorities; and be it further

RESOLVED, that The Medical Society of New Jersey continue to encourage uniform high-quality care for Medicaid patients as well as for private patients.

Upon motion the House agreed to consider Substitute Resolution #6

Substitute Resolution #6 Adopted

b. **Hospital Readmission of Acute Cases**—Resolution #10 (page Tr 110)

The Committee feels that the first "Resolved" should be amended to read as follows:

RESOLVED, that The Medical Society of New Jersey, through its Liaison Committee with the New Jersey Hospital Association, study and devise a mutually acceptable procedure to insure proper disposition of such cases as the need arises; and be it further

The Committee **recommends** that Resolution #10 be adopted as amended.

Adopted as amended by the Reference Committee

c. **Format of Payment Vouchers Under Medicare**—Resolution #12 (page Tr 111)

The Committee feels that the "Resolved" should be amended to read as follows:

RESOLVED, that the Prudential Insurance Company be requested to improve methods for the submission of individual "Explanation of Benefits" data for each patient.

James E. D. Gardam, M.D., who is a delegate of Essex County and a representative of Prudential Insurance Company, spoke regarding a new and improved computerized format for payment vouchers in conjunction with Blue Shield, which should greatly facilitate payment. Blue Shield has recently circularized all physicians in the State regarding alternate methods of reimbursement, which should obviate some of these problems. Nevertheless, the Committee feels that this resolution is worthwhile.

The Committee **recommends** that Resolution #12 be adopted as amended.

Adopted as amended by the Reference Committee

d. **Public Knowledge**—Resolution #14 (page Tr 113)

The Committee **recommends** that the following Substitute Resolution #14 be adopted.

Whereas, apparently, different insurance carriers and third party payors have different schedules of "usual, customary, and reasonable" fees in each county, and only one such fee schedule can be accurate; and

Whereas, these fee schedules have been derived without proper consultation with representative physician groups in each county; and

Whereas, some fees for medical and surgical services are derived by methods which could be considered unreasonable, arbitrary, and capricious; and

Whereas, it is in the public interest that the finances of the health insurance carriers and third party payors be open to public scrutiny; now therefore be it

RESOLVED, that the third party payors' physicians fee profiles and reimbursement formulas be made public knowledge; and be it further

RESOLVED, that the bases for the computation of these schedules be made public knowledge; and be it further

RESOLVED, that third party payors' fee schedules be determined only after consultation with representative physician groups.

Upon motion the House agreed to consider Substitute Resolution #14.

House voted to postpone further discussion and refer both original Resolution #14 and Substitute Resolution #14 to the Council on Medical Services.

e. **Health Insurance Carriers**—Resolution #15 (page Tr 114)

The Committee is of the opinion that the words *"health insurance carriers"* should be changed to *"third party payors"* wherever they appear in the resolution.

The Committee **recommends** that Resolution #15, as amended, be adopted.

House voted to postpone further discussion and refer both Resolution #15 and the Reference Committee proposed amendment to the Council on Medical Services.

f. **Medicare Reimbursement Refusals**—Resolution #17 (page Tr 115)

The Committee feels that the first "Resolved" should be amended by deleting the words *"Social Security Administration,"* and inserting instead the words *"Prudential Insurance Company of America."*

In the final "Resolved" the Committee suggests the deletion of the words *"and to the senior citizens organizations."*

The Committee **recommends** that Resolution #17 be adopted as amended.

Adopted as amended by the Reference Committee

g. **Fitness for Licensure**—Resolution #18 (page Tr 116)

The Committee **recommends** that Resolution #18 be adopted.

Adopted

h. **Chronic Alcoholism**—Resolution #19 (page Tr 117)

The Committee **recommends** that the following Substitute Resolution #19 be adopted.

Whereas, the incidence of Chronic Alcoholism in the United States is constantly increasing; and

Whereas, the number of afflicted alcoholics in need of in-patient hospital care is also increasing; and

Whereas, in many of our hospitals existing policies with regard to the admission of these patients are restrictive or exclusive; and

Whereas, it has been established that in-patient alcoholics do not unduly disrupt normal hospital routines and can easily be managed in a general ward of service; now therefore be it

RESOLVED, that The Medical Society of New Jersey recommend to all hospitals that they review their admission policies for alco-

holics and, if necessary, liberalize them to admit alcoholics; and be it further

RESOLVED, that The Medical Society of New Jersey urge all physicians to abstain from using names of other pathological conditions in place of the diagnosis of "alcoholism," when alcoholism is the primary manifesting problem; and be it further

RESOLVED, that this resolution be presented to the House of Delegates of the AMA at the next annual meeting.

Upon motion the House agreed to consider Substitute Resolution #19. Substitute Resolution #19 adopted.

i. **Control of the Sale of Certain Drugs**—Resolution #21 (page Tr 118)

The Committee **recommends** that Resolution #21 be rejected as imposing requirements that would be impractical of fulfillment. It suggests that the resolution be referred to the appropriate committee of The Medical Society of New Jersey for further consideration and study.

Adopted

j. **Equitable Composition of FDA Panel on Drug Evaluation**—Resolution #22 (page Tr 119)

The Committee **recommends** that Resolution #22 be adopted.

Adopted

k. **Medicaid Waiver Project**—Resolution #25 (page Tr 121)

The Committee suggests that in the final "Whereas," the word "*any*" in the first line be changed to "*this.*"

The Committee **recommends** that Resolution #25 be adopted as amended.

Upon motion the House agreed to consider the following substitute Resolution #25 presented by the Essex County Medical Society (in concurrence with the Reference Committee) which embodied the amendment suggested by the Reference Committee

Whereas, the purpose of the Medicaid Waiver Project is an excellent intent; and The Medical Society of New Jersey supports this additional allocation of funds to the working poor; and

Whereas, a Health Care Plan must be equitable, accessible, and acceptable for all citizens, including the working poor; and

Whereas, the Plan, as presently constituted, deprives the patient of free choice of physician and hospital; and

Whereas, the American system has always protected this right of free choice, as does the present Medicaid plan; and

Whereas, the patient must be given his free choice of physician, clinic, or hospital under this project; and

Whereas, this Plan offers no fiscal guarantees to improve the delivery of health care in the City of Newark; and

Whereas, this Plan, as presently constituted, excludes two Newark Hospitals serving important areas of the city; and

Whereas, this Plan has been designated as a pilot project for other communities throughout the State and Nation; and

Whereas, the planning of this health care system must include input from all segments of the health care professions and the consumers of such health care; now therefore be it

RESOLVED, that The Medical Society of New Jersey go on record as being opposed to this Plan as now outlined; and be it further

RESOLVED, that this Plan not be implemented as presently constituted; and be it further

RESOLVED, that an immediate meeting be called of directly involved consumers, physicians, dentists, hospitals, the State Department of Health, the Department of Institutions and Agencies, and other providers of health services to plan appropriate changes to provide excellent care with free choice of physician, clinic, and/or hospital; and be it further

RESOLVED, that the Newark Comprehensive Health Services Plan Advisory Board be enlarged by representatives of the Community and of the providers of health care; and be it further

RESOLVED, that The Medical Society of New Jersey immediately forward copies of this resolution to Governor William T. Cahill and Commissioner of Health James R. Cowan, M.D., R. L. Clifford, Commissioner, Department of Institutions and Agencies, and William Dougherty, M.D., Medicaid Waiver Project, New Jersey Department of Health.

Adopted



Convention Buffet-Dance

Reference Committee "G"

Frank R. Begen, M.D., Chairman

Reference Committee 'G" met on Saturday, May 12, 1973, with all members present: Doctors Robert H. Areson, George E. Barbour, Delma W. Caldwell, Harry W. Fullerton, and the chairman. Approximately 24 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees—Items**

a. **Environmental Health** (page Tr 23)

The Committee **recommends** that the report be filed.

Adopted

b. **Fitness to Drive** (page Tr 23)

The Committee **recommends** that the report be filed.

Adopted

c. **Sanitary Disposal of Sewage from World Trade Center Buildings in New York City** (page Tr 23)

The significance of sewage in ocean bathing water is predicated not on quantitative factors, but on the fundamental distinction between human waste and detergecides. A proper regard for the public health demands total divorce of sewage from potable and bathing beach waters.

The Committee **recommends** that the report be filed.

Adopted

2. **Public Health** (page Tr 75)

The Committee **recommends** that the report be filed.

Adopted

3. **Cancer Control** (page Tr 76)

The Committee **recommends** that the report be filed.

Adopted with approval of the contained recommendations

4. **Child Health** (page Tr 76)

The Committee **recommends** that the report be filed.

Adopted

5. **Conservation of Vision, Hearing, and Speech** (page Tr 77)

The Committee **recommends** that the report be filed.

Adopted

6. **Environmental Health** (page Tr 78)

The Committee **recommends** that the report be filed.

Adopted

7. **Maternal and Infant Welfare** (page Tr 78)

The Committee **recommends** that the report be filed.

Adopted

8. **Resolution:**

Better Protection of the Public From Eating Places Found Unsanitary—Resolution #13 (page Tr 111)

The Committee **recommends** that the following Substitute Resolution #13 be adopted.

Better Protection of the Public From Food Handling Establishments Found Unsanitary

Whereas, Chapter 12 of the State Sanitary Code obliges all restaurants to post in a prominent place "their latest summary health inspection report and the three-page detailed report on request," and such posting has been found to be performed improperly; and

Whereas, although State and local health personnel have made adequate inspections and have instituted legal procedures against repeated violators of the health code, the public remains uninformed concerning unsatisfactory food handling establishments because little publicity has been given to violators; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey request the Governor, the Legislature, and the State

Department of Health to continue *to take steps to insure that all persistent violators of the health regulations be publicized in appropriate news media.*

Upon motion the House agreed to consider Substitute Resolution #13.

Amended by the House by inserting the words "to continue" after the word "Health" in the Resolved.

Adopted as amended by the House.



Incoming President Boylan accepts Presidential Certificate from President D'Elia

Reference Committee "H"

Robert A. Weinstein, M.D., Chairman

Reference Committee "H" met on Sunday, May 13, 1973, with all members present: Doctors John R. Ayers, Sherman Garrison, Sidney Woltz, Myra R. Zinke, and the chairman. Approximately 15 delegates and members were present to discuss the various items under consideration.

1. **Annual Meeting** (page Tr 29)

The Committee commends Doctor Arthur Bernstein, Chairman of the Committee on Annual Meeting, for the excellence of his report and for the accomplishments of his Committee throughout the year.

It was suggested that the Committee on Annual Meeting earnestly consider alternate cities where the annual meeting could be held, with Atlantic City being the location every second or third year.

The Committee **recommends** that the recommendation on page Tr 31 of the annual report be approved.

Adopted

The Committee **recommends** that the report be filed.

Adopted

2. **Scientific Exhibits** (page Tr 31)

The Committee commends the Committee on Scientific Exhibits for their excellent selection of exhibits. In discussing this report, there were two suggestions submitted that the Committee feels have merit: (a) That medical students from the College of Medicine and Dentistry of New Jersey (Newark and Rutgers) be encouraged to submit scientific exhibits and that $150 be given to each student to defray expenses when the exhibit has been

accepted. Also, as in the past, that there be no fee charged and that awards be presented for those exhibits with distingushed merit; (b) That the Committee on Annual Meeting visit national meetings of organizations such as the AMA, American College of Surgeons, American College of Physicians, and the American Academy of Family Physicians, to solicit outstanding exhibits to participate in MSNJ's annual meetings.

The Committee **recommends** that the report be filed.

Adopted

3. **Scientific Program** (page Tr 32)

There was considerable discussion concerning the current policy of accepting contributions for the educational fund of MSNJ in lieu of exhibiting. The Committee wished to make note that technical exhibitors should be encouraged to present their exhibits at our annual meeting, but we would gratefully accept the contributions should they prefer to do this.

The Committee **recommends** that the report be filed.

Adopted

4. **Honorary Membership** (page Tr 34)

The Committee **recommends** that the report be filed.

Adopted

5. **Woman's Auxiliary Advisory** (page Tr 54)

The Committee commends the Woman's Auxiliary for their excellent work throughout the year, especially the outstanding accomplishments in connection with the AMA-ERF.

The Committee **recommends** that the report be filed.

Adopted

6. **Nominations for Emeritus Membership** (page Tr 101) and Supplemental (page Tr 102)

The Committee **recommends** that the report be approved.

Adopted

7. **Resolutions:**

a. **Establishment of a Section on Emergency Medicine**—Resolution #7 (page Tr 108)

It was noted that there are over 200 New Jersey physicians holding membership in the National Society of Emergency Medicine.

The Committee **recommends** that Resolution #7 be adopted.

Adopted

b. **Section on Physical Medicine and Rehabilitation**—Resolution #8 (page Tr 109)

The Committee **recommends** that Resolution #8 be adopted.

Adopted



Convention Buffet Dance

Report of the Nominating Committee and Election—May 13, 1973

E. Vernon Davis, M.D., Chairman

OFFICE	TERM	NOMINEE AND COUNTY
President-Elect	1 year	James A. Rogers, M.D., Passaic
1st Vice-President	1 year	John J. McGuire, M.D., Essex
2nd Vice-President	1 year	John S. Madara, M.D., Salem
Secretary	1 year	Louis F. Albright, M.D., Monmouth
Treasurer	1 year	Samuel J. Lloyd, M.D., Mercer
Trustees:		
1st District	3 years	Francis J. Benz, M.D., Morris
4th District	3 years	Meyer L. Abrams, M.D., Burlington
5th District	3 years	David R. Brewer, Jr., M.D., Gloucester
Judicial Councilors:		
3rd District	3 years	Albert F. Moriconi, M.D., Mercer
5th District	1 year	John A. Surmonte, M.D., Salem*
AMA Delegates:	1½ years	Joseph R. Jehl, M.D., Passaic
	2 years	Joseph P. Donnelly, M.D., Hudson
	2 years	Louis F. Albright, M.D., Monmouth
AMA Alternate Delegates:	2 years	George L. Benz, M.D., Essex
	½ year	Alfred A. Alessi, M.D., Bergen**
	2 years	Alfred A. Alessi, M.D., Bergen
	2 years	Robert E. Verdon, M.D., Bergen
	1 year	A. Guy Campo, M.D., Gloucester***
Delegates and Alternate Delegates to Other States:		
New York		
Delegate	1 year	Albert F. Moriconi, M.D., Mercer
Alternate	1 year	Josiah C. McCracken, Jr., M.D., Atlantic
Connecticut		
Delegate	1 year	Warren H. Knauer, M.D., Union
Alternate	1 year	Gastone A. Milano, M.D., Atlantic
Administrative Councils:		
Legislation		
2nd District	3 years	John J. Crosby, Jr., M.D., Hudson
3rd District	3 years	Leon A. Fraser, M.D., Mercer
Medical Services		
2nd District	3 years	James S. Todd, M.D., Bergen
3rd District	3 years	Frank Campo, M.D., Mercer
Mental Health		
4th District	3 years	Edward A. Schauer, M.D., Monmouth
5th District	3 years	Miles E. Drake, M.D., Cumberland
Public Health		
2nd District	3 years	Kendrick P. Lance, M.D., Passaic
3rd District	3 years	Thomas McLaughlin, M.D., Middlesex
Public Relations		
3rd District	3 years	Howard D. Slobodien, M.D., Middlesex
6th Member	3 years	Francis X. Keeley, M.D., Camden
Standing Committees:		
Annual Meeting	3 years	Robert Brill, M.D., Passaic
Finance and Budget	3 years	Barry M. Kotler, M.D., Middlesex
Medical Defense and Insurance	3 years	Anthony DeSpirito, M.D., Monmouth
Medical Education	3 years	Frank C. Snope, M.D., Hunterdon
Publication	3 years	Daniel B. Roth, M.D., Bergen
Woman's Auxiliary Advisory	3 years	Alexander Kovacs, M.D., Union

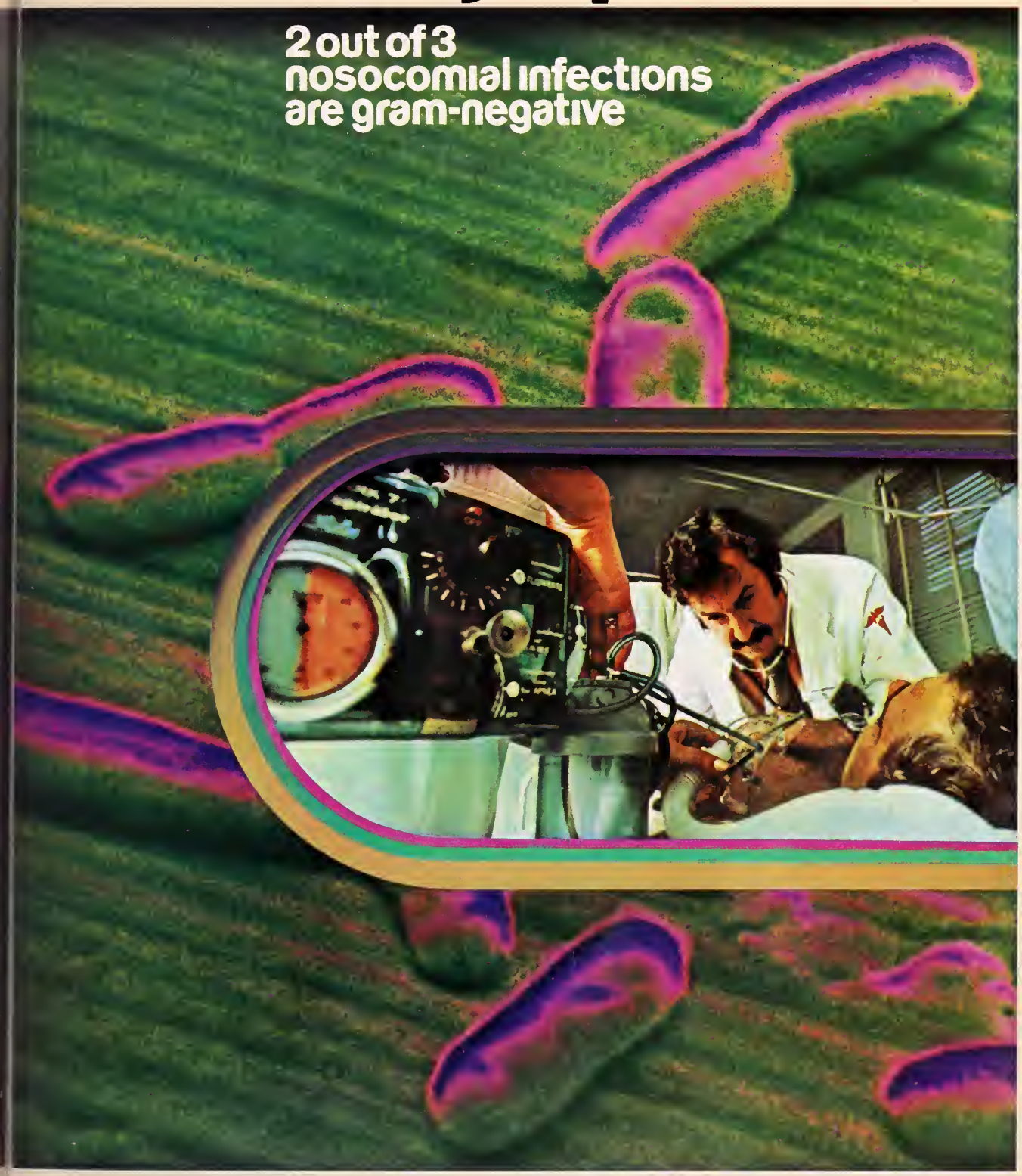
* Nominated and elected by the House to fill unexpired term of John S. Madara, M.D., who resigned after being elected Second Vice President

** Nominated and elected by the House to fill unexpired term of Joseph R. Jehl, M.D., who was elected AMA Delegate.

*** Nominated and elected by the House to fill unexpired term of Louis F. Albright, M.D., who was elected AMA Delegate.

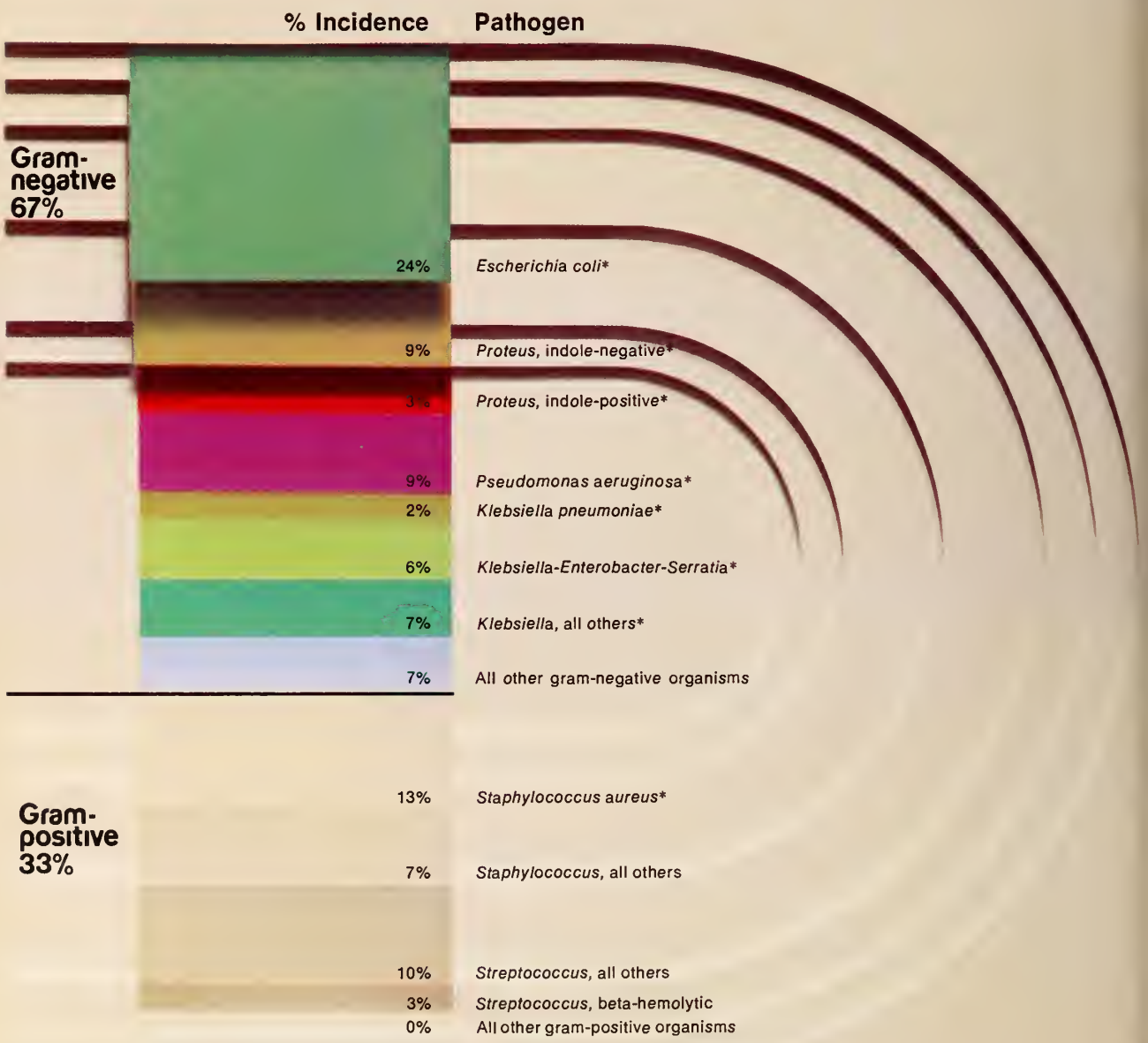
Schering

On all in-patient services... a major problem



Gram-negative bacteria magnified 10,000 times—color-tinted

Commonly encountered pathogens on all hospital services



Total pathogens 21,972
Source: Gosselin Audit of Pathology Cultures—1971

*GARAMYCIN Injectable is effective against susceptible strains of the pathogens indicated

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Schering

A highly appropriate spectrum for today's problem pathogens

ARAMYCIN Injectable offers a high ability of effectiveness against susceptible ns of seven out of seven major gram- itive pathogens. These are:

Escherichia coli
Proteus, indole-negative
Proteus, indole-positive
Pseudomonas aeruginosa
Klebsiella } species
Enterobacter } species
Serratia } species

ARAMYCIN Injectable has also been shown e effective in serious staphylococcal infec- s. It may be considered in those infections n penicillins or other less potentially toxic js are contraindicated and bacterial ceptibility testing and clinical judgment cate its use.



serious gram-negative infections (neumonia, urinary tract infections, pticemia, and wound infections)*
to susceptible organisms

Start with Garamycin

■ **Broad gram-negative spectrum**
Because of its broad gram-negative spectrum and its well-established clinical efficacy, GARAMYCIN Injectable can be considered for initial therapy in suspected as well as documented gram-negative sepsis.

Stay with Garamycin

■ **Susceptibility of causative organisms confirmed**
The results of susceptibility tests will, in most cases, demonstrate the causative organisms' sensitivity to GARAMYCIN Injectable. However, the decision to continue therapy with this drug should also be based on the severity of the infection and the important additional concepts contained in the Warning Box.

■ **Relatively low incidence of adverse reactions**
Risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

■ **Bacterial resistance has not been a problem**
In the laboratory, resistance has been demonstrated to develop slowly in stepwise fashion. No one-step mutations to high resistance have been reported to date.

On all in-patient services...

Garamycin®
gentamicin sulfate injectable

I.M./I.V.

40 mg. per cc.
Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

WARNING
Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of ototoxicity requires dosage adjustments or discontinuance of the drug.

In event of overdose or toxic reactions, peritoneal dialysis or hemodialysis will aid in removal of gentamicin from the blood.

Serum concentrations should be monitored when feasible and prolonged concentrations above 12 mcg./ml. should be avoided.

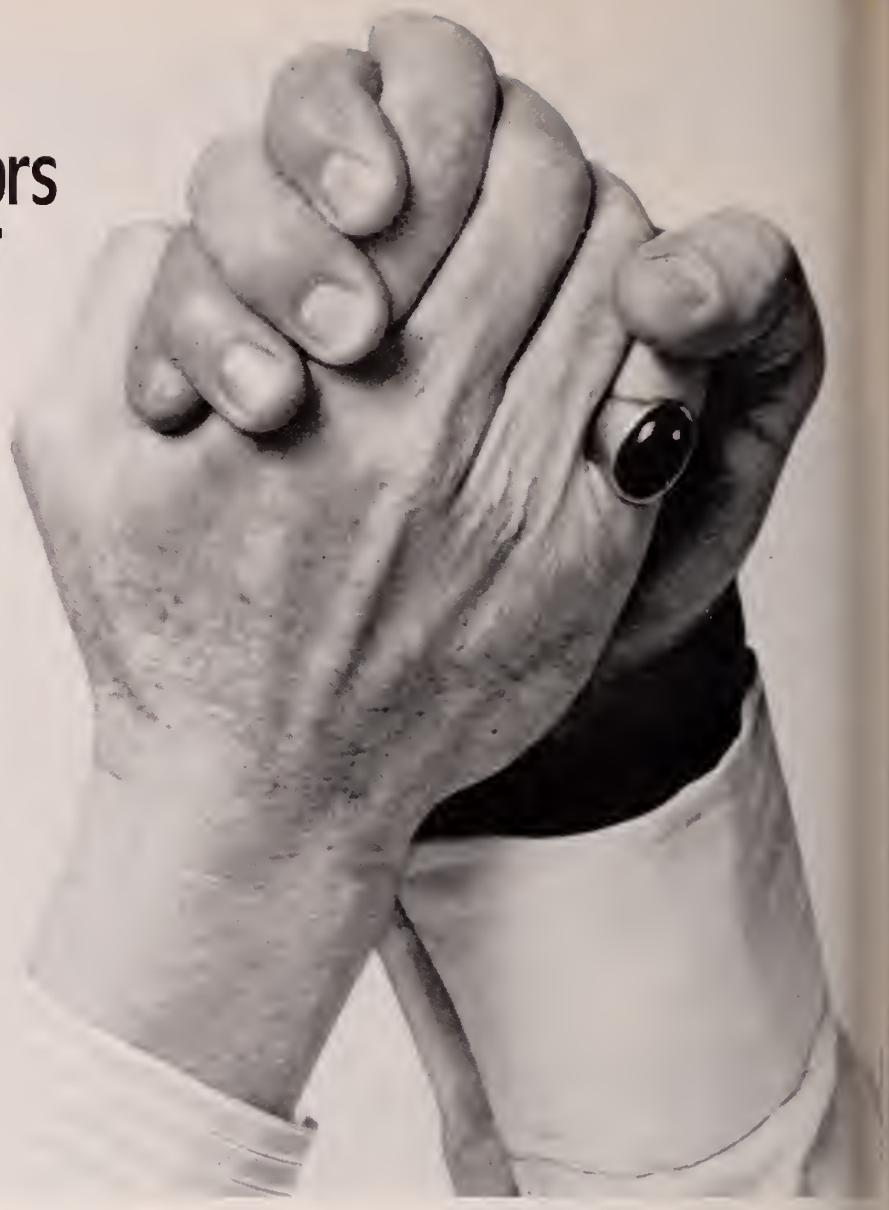
Concurrent use of other neurotoxic and/or nephrotoxic drugs, particularly streptomycin, neomycin, kanamycin, cephaloridine, viomycin, polymyxin B, and polymyxin E (colistin), should be avoided.

The concurrent use of gentamicin with potent diuretics should be avoided, since certain diuretics by themselves may cause ototoxicity. In addition, when administered intravenously, diuretics may cause a rise in gentamicin serum level and potentiate neurotoxicity.

USAGE IN PREGNANCY Safety for use in pregnancy has not been established.

See Clinical Considerations section which follows...

Must vasodilators and therapy for other diseases come into conflict?



not if the vasodilator is

VASODILAN®
(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Until We Meet Again*

Richard I. Nevin
Executive Director—1951-1973

Cardinal Wolsey is remembered for saying, "Farewell, a long farewell, to all my greatness!", and Juliet declared " . . . parting is such sweet sorrow that I shall say goodnight 'till it be morrow." But I'm not here to say "good night," nor have I Juliet's threatening propensity for prolixity. Moreover, if I have title to even a limited portion of greatness I have no inclination to forego it. As a matter of fact, this is a farewell address only in the sense that, as I relinquish my office as Executive Director of this beloved Society, I do so with a fervent prayer to God that all of you may, in all that you do, fare well!

As of the first of June I shall enter upon my formal retirement as your Executive Director. For almost twenty-three years, the paths of our daily lives have paralleled and intertwined. Now to some extent they will diverge. In 1951 I gave my hand and my heart to the contract to serve the Society. Now in effect I am about to disengage my hand but as for my heart—that is another matter. It has become inextricably committed, so that, though the orbits of our lives may be less intimately related, my heart will still beat in close cadence with yours. Be the future for me long or short, as long as I live there will always be something of The Medical Society of New Jersey in the heart of me and, I hope, something of me in the heart of The Medical Society of New Jersey.

I say no farewell, therefore, to the Medical Society or the House of Delegates for the reasons that I have set forth, but also because in 1966, with gratifying kindness, you conferred upon me the status of honorary membership. So, until I die I shall proudly claim membership with all of you and shall exercise my privilege to be concerned about your activities and to participate in your annual meetings.

I shall no longer have the honor and responsibility of being your chief of staff, because the world of your affairs is becoming an increasingly heavy globe to bear, and Atlas should have strong shoulders and no indication of progressively weakening hams.

Through the years I have constantly striven to sustain and advance the ideals, and to maintain and preserve the dignity and status, of the profession of Medicine. Indeed, I am convinced, that a profession or a people bereft or despoiled of worthy and unselfish ideals is a profession or a people debased.

I urge you to be true to your highest professional and personal ideals and—despite the allurements offered by a corrupt materialistic society—never to stoop to conquer!

So, in a limited sense, I take my leave, but it is not, in the undertaker's lugubrious term, "a last leave." My understanding and intent will, I hope, be clear when I say to all of you: May God hold you in the very hollow of His hand, as I shall hold you in the hollow of my heart . . . until we meet again!

*Farewell address of Executive Director, Richard I. Nevin, delivered to the House of Delegates, 207th Annual Meeting, MSNJ, May 13, 1973, Atlantic City.



DINNER DANCE

Louis F. Albright, M.D., Toastmaster

Dr. Louis F. Albright: Will you please take your seats? We're rather late. Ladies and gentlemen, a brief preliminary welcome to the dinner. The time is now appropriate for the invocation. Unfortunately Dr. Neiman, who has traditionally given the invocation couldn't be with us tonight, so I will attempt to fill his shoes. Will you all bow your heads please?

"Our Heavenly Father, we thank Thee for the privilege of having had William J. D'Elia for our President during the past year. May he soon forget his frustrations and long remember his accomplishments and his many enjoyable moments. We thank Thee for these gifts which we are about to receive through Thy bounty. Bless them to our use and us to Thy service, and make us ever be mindful of the needs of others. Amen."

I shall now ask Mrs. Charles Gandek, President of the Woman's Auxiliary of The Medical Society of New Jersey, to bid you your formal welcome. Mrs. Gandek.

Mrs. Charles Gandek: It is a great privilege and pleasure for me to welcome you all here this evening. This is your evening to throw away your cares and your responsibilities, so eat, drink, be merry, and have fun.

Dr. Albright: Thank you, Mrs. Gandek. I would like to introduce those at the head table. We'll start all the way down the table to my left, Dr. Vernon Davis, our immediate Past-President, and Mrs. Davis, whom you all know, the wife of our immediate Past-President. We next have our speaker of the evening whom we'll introduce to you later in greater length, John Zapp, D.D.S. Next the lady from whom you've just heard, Mrs. Gandek, President of the Woman's Auxiliary. Dr. D'Elia, our guest of honor, and Dr. D'Elia's lovely wife Agnes. My dear wife, Roberta. For the moment Mrs. Abbamonte, President-Elect of the Woman's Auxiliary, has left the hall. I presume she will be back; we shall take the opportunity to introduce her to you later. Next we have Dr. Matthew Boylan, President-Elect, and Matt's gracious wife Dorothy. I'd now like to introduce some of the Fellows of the Society. As you are well aware the Fellows of the Society are its past presidents. At table 14, Dr. Charles H. Calvin and Mrs. Calvin. Will you stand up, Charles? At table #12, Dr. John J. Bedrick. Table #10, Dr. Joe Jehl and his wife. Table #24, Dr. and Mrs. John F. Kustrup. Table #10, Dr. and Mrs. Louis K. Collins. Table 11, Dr. and Mrs. Nicholas A. Bertha. Table #20, Dr. Emanuel M. Satulsky. At this time I would like to take this opportunity to introduce one who has seldom sat at a table, our Executive Director, Richard I. Nevin and Mrs. Nevin. Where are they? Way in the back. Richard is trying to get as far away from this head table as possible. I might add that as of June 1, 1973 Mr. Nevin will be our Emeritus Executive Director. I would now like to introduce our honored guests. The first of these, the Honorable Joseph J. McGhan M.D., Senator from Atlantic County at table #2. Mrs. Donald Andersen, National Director of the Woman's Auxiliary American Medical Association, table #7. Mr. and Mrs. Harold J. Ruvoldt, Sr., President of the New Jersey State Bar Association. Mrs. Marie Andreazzi, President of the American Association of Medical Assistants, State of New Jersey. Dr. and Mrs. Michael Sutula, President of the New Jersey Association of Osteopathic Physicians and Surgeons. Dr. and Mrs. William C. Ebeling, President of the Medical and Chirurgical Faculty of Maryland. Dr. and Mrs. Robert S. Sandford, President of the Pennsylvania Medical Society. Mr. and Mrs. Vincent A. Maressa of our staff, and Mr. Nevin's successor. I would also like at this time to say that our guests have been escorted by our hosts of the evening, Doctors Jehl, Collins, Bertha, and Ornaf. At this moment we have some other guests who might be more appropriately introduced by someone else at the head table. I'll call on Dr. D'Elia at this moment to make a further introduction. Bill, come up here.

Dr. William J. D'Elia: Thank you very much, Lou. I'd like to take this opportunity to introduce to you members of my family. We are fortunate to have most of them together tonight. Sitting at table #4 we have with us my daughter—or our daughter, excuse me, Agnes—our oldest child, Mrs. Janet Power. Janet, would you stand a minute please? Janet has three lovely daughters. They are our pride and joy. Next our son, who has been out in San Francisco since last summer, and whom I haven't seen in all that time. He suddenly showed up on Sunday to spend some time with us, Bill, Jr. Next to him is our younger son, Hugh, who has come down to see us for the day. My brother and his wife, Dr. and Mrs. Art D'Elia. And my partner and his lovely wife, Dr. and Mrs. Milbauer. I spent considerable time away, as you would guess, and every time I came home I wondered what had happened in our practice. Tonight when Jack arrived he said, "You needn't come home. We sold the practice." Maybe I can get myself appointed receiver or something of that sort. I see that the main course is arriving, so enjoy your dinner.

Dr. Albright: I have a few more introductions to make. Unfortunately I wrote some of my notes here wth my watergate ballpoint pen, you know the one that's filled with disappearing ink? I'll have to review these, and I'd like to introduce some more of our guests. First we have Mrs. Judith D. Francois who is the daughter of Mrs. Gandek. Mrs. Francois, would you stand please? I want also to introduce Raymond T. Sullivan, Jr., Assistant Director of the Department of Field Service of the American Medical Association at table #6. Ray, will you stand up? Thank you. One of our fellows, Dr. Kenneth Gardner, table #13, Ken, I'd like also to introduce the President of the Monmouth County Medical Society, Dr. Myra Zinke. It also gives me great pleasure to introduce the wives of two of our late Fellows. Mrs. Louis S. Wegryn; Edna Mae, will you stand up please? And Mrs. Jesse McCall, Louise. Are there Fellows whom I have missed? We had a rough afternoon, as all of you who were in the House of Delegates know, and to me it's sort of, you know, as if you had pitched the first game of a double-header and then you are called in in relief in about the sixth inning. But the refreshments seem to have helped a little. I might add there have been many occasions in my years of working in our Medical Society when I have been awed and actually a little bit trembly as I undertook my assigned tasks. I always remember an occasion when Dan Featherston was rather suddenly taken ill, and I was called upon to take his place in a meeting of the Nominating Committee for the first time. This is really the type of experience that shakes you. Or I remember when Joe Donnelly asked me to present our Society's viewpoint on the floor of the AMA House of Delegates for the first time. I always thought I could speak anywhere, but that morning I went through the motions and no sounds came out. But these were occasions for trepidation and what we used to say the "S's"—Sweating and Shaking—but for me tonight this is a somewhat similar situation. I am keenly aware that for the twenty-two previous annual dinners the meeting has been presided over by our retiring Executive Director, a most accomplished speaker and toastmaster, Mr. Richard I. Nevin. As you all know Dick's act is a very difficult one to follow. However, the occasion is certainly an inspiring one, and with your indulgence I'll do my best. This particular moment is one of celebration and sadness as we hail our guest of honor at the same time we bid him goodbye. These mixed emotions have invariably produced comment, but although the total context was far different, Shakespeare's words, "Parting is such sweet sorrow," may briefly in feeling express our thoughts at this time. Bill D'Elia and I have been very close friends and neighbors for many years. Over the past several years we've spent many hours together, and I had an unusual opportunity closely to observe his actions and reactions to the many duties, vexations, and frustrations of this demanding office. His deep involvement in the duties of the Presidency and his willing assumption of the responsibilities of this office, which were obviously going to prove wearing and exhausting, have been evident to all of you. He has acquitted himself well. He

has been tireless, and the scope and range of his contacts and travels must have established some sort of Presidential record which unfortunately probably will never appear in Guinness' Book of Records. He has represented us creditably and forcefully in our complex relationships. His hand on the helm has been firm. Our course has been responsibly plotted and straight-sailed with the result that an unusual number of objectives have been attained in this year, and many others are now within hailing distance. He has performed in the hallowed and best tradition of our Presidential office and has thoughtfully used the assistance of his many willing associates. We are proud of him and the record he has written in our annals. Dick Nevin has often spoken of the aristocracy of the Fellowship. As the President fades out a new Fellow is proudly welcomed. As Bill leaves the Presidential Office his predecessors in the Presidential chair induct him into the Membership of the Fellows. I call on Dr. Vernon Davis to come up to the podium. Vernon, will you? I ask Dr. Davis to perform the last function of His Immediate Past-Presidency, by welcoming Dr. D'Elia as a Fellow of The Medical Society of New Jersey. I now introduce and turn the meeting over to Dr. Vernon Davis.

Dr. Vernon Davis: I would like to call the following Fellows up to the dais: Dr. Kenneth Gardner, Dr. Charles Calvin, Dr. John Bedrick, Dr. Joseph Jehl, Dr. John Kustrup, Dr. Louis Collins, Dr. Nicholas Bertha, and last but not least Dr. Emanuel Satulsky. All of you who were present yesterday remember that Dr. D'Elia said it was a great honor to be the President of The Medical Society of New Jersey. It is a great honor for us tonight to honor a great physician as the newest Fellow of this great Society. I have known Dr. D'Elia for several years and have sat beside him on many occasions at our Trustees' meetings and otherwise. He has convinced me that he is one of the most devoted men to the cause of medicine that I have ever known personally, and as a result of the aforesaid I count it an honor and a privilege to pass to him the Fellow's Key.

Dr. Albright: Dr. Davis, I thank you. At this moment we'll give Dr. D'Elia his first duty of his newly proclaimed status, and a very pleasant one it will be. Dr. D'Elia, I would like you to present this Fellowette's Pin to Mrs. Gandek. Mrs. Gandek, will you come to the podium?

Dr. D'Elia: Mrs. Gandek, your pin. It's my responsibility from, I guess, precedent in past years for me to pin or to apply. . . . Where do you want it? I'm a little nervous. It's a little different from zipping up your wife's zipper. Congratulations and good luck to you. You've done a good job. Mrs. Gandek, as you know, just retired as President of the Woman's Auxiliary, and she is now a Fellowette.

Dr. Albright: I would also like to take this opportunity to say that Mrs. Louis Abbamonte, the President-Elect of the Woman's Auxiliary unfortunately was taken ill tonight and this explains her absence from the head table. Often at these meetings the county which claims the retiring President has seen fit to present him with a watch or some token of the county's appreciation, but Bill's got lots of watches and I doubt if one more would get him to meetings any more on time than he usually does in the past. My county has instructed me . . . you know, we have to live with him from now on. We can't be too liberal with the praise. But what we would like to do is pay a brief tribute to all of the Past-Presidents, and in this particular respect in our county we've often discussed the fate of the Past-President. The Past-President reaches this pinnacle, and then tradition has it that in some way he sort of drops out of the active picture. There are some primitive counterparts of this in some cultures of deepest Africa and New Guinea. The Chief of a Staff when his numerous wives have not produced any offspring for two or three years is told that he's outlived his usefulness, and he sort of disappears. Well, obviously I'm not about to promote promiscuousness or anything of that kind, but in some ways probably the tradition that we employ is rather wasteful of human talent at times. I refer particularly to the ceremony of interment which we seem to

inflict on our retiring Presidents. Nobody is more conscious of the need to infuse young blood and to have the steady transfusion of younger men into the Executive Committees and bodies of our Medical Society, but we often feel that maybe somehow we lose some of the expertise that these men have accumulated who have served through the Presidency when we sort of really cast them aside. You know, at this particular hour the pronouncement of expiration has been duly made. The Past-President will then lie in state for the next year as the Immediate Past-President. He is on display the third Sunday of every month if you care to come to Trenton. You can see him in various stages of activity or inactivity. One year hence he is dutifully laid in his final resting place and the epitaph "Fellow" is chiselled on his marker and in the archives of the Society. He is expected as a well-behaved corpse to take little further part in the business of the Society, to rock no boats, to haunt no houses, and in no way play the part of a blithe spirit by involving himself in the Society's activities other than an occasional possible partial resurrection as a Delegate or an Alternate Delegate to the AMA.

Oh, I will admit that I have exaggerated the status of the Past-President, but I strongly feel that this practice deserves this emphasis. At the end of the Presidential year our Executive Officer really has reached a true performance pinnacle. His worth to our Society has in many ways reached its peak. He has behind him a variable number of years of service in the Society. He has had three years of intensive training and indoctrination during his two years of Vice-Presidency and his one year as President-Elect. In recent years we have greatly heightened the intensity of this preparation. During the year of Presidential tenure he has had the responsibility and opportunity of representing your Society at every level of contact. He has established relationships with legislative and educational leaders, political figures, deans of our medical schools, and many other executives of agencies and organizations related to the activities of our Society. He has visited virtually all of our county societies as well as our adjacent state societies, and has come to know and be known intimately by the leaders of these component groups. At this particular point in time I believe it is no exaggeration to state that our retiring President is probably our best-versed member in a myriad of relationships and problems which our Society finds itself involved with in our complex spectrum of activities. In fact, you know, we have too much time and effort invested in our retiring Presidents, past, present, and future, to continue this wasteful expenditure of talent and resources in which we annually indulge when we rather automatically exile our Past-President to a limbo of traditional inactivity in our organization. It seems to me that there are many positions in which they have special and unique expertise and knowledge. They could certainly very well put this knowledge and expertise to work we'll say in the Judicial Council where their prestige and maturity would certainly enhance the authority of the Judicial Council. There are certainly special committees and special assignments where the talents of our retiring Presidents could be used.

Obviously I have no particular solution to what we might call a problem or a circumstance, but maybe in the coming months we will find more productive and fruitful fields for the talents of our retiring Past-Presidents. It certainly is worth thinking about. We do tonight have a special speaker whom I shall present to you very shortly. When we were making up the format of the meeting tonight somebody said, "Well, you say something about the things that are happening at the local level, and Dr. Zapp, our speaker of the evening, will talk about what's happening in Washington." I have very little to add to what I've already said at the local level, except one thing which has impressed me. As many of you know I am the secretary of the Society and in this last year we have taken in a tremendous number of new members. Actually, into associate membership and moving up to full membership we have an excess of 800 members. Of these almost exactly 50 per cent are non-citizen physicians who will be

practicing with us in the State of New Jersey. These men and women are our colleagues. I might add that they eagerly join the Medical Society. Virtually all of them join the AMA, and I'm sure that they want to be part of our organization. Unfortunately, I see almost none here tonight, and I'm sorry to state that I don't often see them at the County Medical Society meetings. They're our colleagues, and I think somewhere during the summer months when you have time to think about it at each county level (because this is where the effort must be expended) a great attempt must be made to bring them into full participation in the Medical Society. Our new colleagues have all declared their intent to become citizens but have various periods of time to wait. The majority are citizens mostly of countries in the Far East—Taiwan, the Philippines, India, Korea, Pakistan, Iran—and I am sure that all of these physicians have unique problems that we could help them with—language problems. We are laying down rules for continuing medical education, and yet I'm afraid we haven't given much thought to how we can make the facilities for continuing medical education available to them. In the coming summer months many of the medical societies will be having annual outings, social events, in which a great effort should be made to get these new colleagues of ours out and to become part of our organization. I hope that we can do something about this.

I will now introduce the main speaker of the evening, John Zapp, D.D.S., Assistant Secretary of Health Legislation, Department of Health, Education, and Welfare, Washington, D.C. Dr. Zapp.

Dr. John Zapp: Thank you very much, Dr. Albright, and my congratulations to you, Dr. D'Elia and Mrs. Gandek. Ladies and gentlemen of the head table and in attendance, I was asked to spend some time with you this evening to discuss the Administration's position as it relates to health care policies. I appreciate the opportunity to do that and to share particularly with you at your 207th Anniversary. I might say more than just health care policies, the fact that what I think we have is a goal. I don't think that goal is any different than your organization's this year or than it was perhaps 207 years ago when it had its inception. It's very simply, adequate health care for all the citizens in our country. Arriving at that goal however is not quite so simple. Public policy-making in health care is somewhat like going through a mine field. You may know that it's there but you can still be blown out of the water. The most dangerous mine field of all and the one that Washington perhaps is grappling with the most at the current time and in recent years is the financing for medical services. Let's compare something that's been in the headlines for the last six months or so, and that's the climb in beef prices, with the prices of a hospital room. From 1962 through last year the beef prices in this country rose only some 39 per cent. That was before the recent rise. But during the same period of time we saw that hospital rooms in this country, the daily charge, went up some 165 per cent. In other words, the hospital room increase was some four times the rise in beef prices during that ten-year period of time. Many people were asking, "Why aren't the consumers in this country as outraged perhaps over the rise in hospital costs as they have been recently over the rise in beef prices?" Well, there are a number of good reasons for this, perhaps not too well understood. First of all, people go to the supermarket every day, but they are only rarely hospitalized. This means that they are obviously not exposed to that increase nearly as often as they are to higher food prices. Secondly, not everybody pays for his own health care costs, but almost everybody has to pay, so to speak, cash on the barrel head when he goes to the supermarket. What's more, most hospital costs are paid for indirectly, either through health insurance or through your taxes through the forms of federal reimbursement and Medicaid and Medicare. I suppose an additional factor is that a good portion of that health insurance today is being underwritten by the employers. Also, I think we'd have to factor in the increase in quality and sophistication for the delivery of care that has resulted from biomedical and

other types of research and improved practices. There's a third major difference in the price behavior of health care from that of food. Surplus food supplies tend to lower food prices in response to the supply and demand mechanism, but supply and demand is something of a one-way street in health care. If you increase the supply of let's say surgeons by 25 per cent you don't automatically decrease the cost of surgical procedure. There are too many other costs and marketing factors that are at work to allow this to happen. But on the other hand if you increase the consumers' access to health care through health insurance or programs like Medicaid and Medicare you can and actually do drive up the price of health care. The lesson is very simple. The medical marketplace operates under a unique and complicated set of guidelines, and woe to the public policy-maker who ignores them. Having recognized this, however, does not free an individual or an Administration or a President or a Congress from the need to act responsibly in improving the quality and access to health care that the American public needs. Healthy people are the bedrock of any vigorous nation, and we have not yet reached that health care utopia in our country. But people have been getting more and better health care as our statistics indicate, more favorable life expectancy, decrease in infant mortality, and fewer days lost from work and school as a result of illness. But it brings me to a point that's often evaluated, as you look at these indices and then at what the cost of health care is in this country where it's reached a point of 7.3 per cent of the gross national product. Just the health care expenditures in our department are 10 per cent of the federal budget. But nobody is really quite satisfied that we're spending the federal health care dollar in the right way, and that's the dilemma that you and we must share because a solution somehow or some type of federal or congressional action will be forthcoming. How responsible and how reasonable that will be will depend on us collectively. In the current battle over the budget ceilings, that you've read about in the Washington papers I'm sure, the charges that the President's been cutting back in human resource spendings simply aren't true. The fiscal budget for next year is some 269 billion dollars. That's for the entire federal government. That's 19 per cent over what it is this year at a time when we're just barely keeping from having to have a tax increase. But 54 per cent of that alone is going into the human resources, and a very, very significant percentage of that is going into health care expenditures. So spending isn't being cut back in human resources or in the health area. What we've been doing, or would propose to do I would hope, is to make that money available perhaps in a different and, we would hope, in a much better way than we have in the past. We've done that by proposing to terminate and in some cases phase out what we consider to be ineffective programs, to retarget the money on more effective programs. In the field of health a number of programs have grown that need to be re-examined for their effectiveness and for their relevance. Some of these health care programs overlap each other. Some have outlived their purpose. Others have over-reached their purpose. Others never had a chance of achieving the purpose which their authors intended.

The new Attorney General designee, L. A. Richardson, who was the secretary of HEW at the time that we were putting together the fiscal 1974 budget last year, directed our planning people to do an analysis of this myriad of programs and authorities that we have in HEW at that near 90-billion-dollar budget. I think he has a fine mind, and he felt that there must be some way to rationalize that type of authority in the number of programs that we have. He came up with some very interesting statistics after, so to speak, plotting on the wall that our Department in Health Education and Welfare really only had about 8 or 10 different purposes of assistance to individuals and education and so forth. We found that we have 300 separate programs in the Department. We found that 56 of those programs tend to overlap and duplicate each other one way or another. We found that another 34 of them tended to overlap or duplicate other similar programs

in other agencies of the Federal Government. So in looking at that weed garden that had grown up over the years we felt that the time was ripe for an examination of the Federal Health Care Program. We believe that this analysis will not only be useful in culling out some wasteful programs, but we thought that the analysis itself would form the basis for a rationale that we may use in evaluating future and competitive programs that would come about as a result of congressional action.

We began on the premise that there are appropriate federal roles and that there are inappropriate roles. It is inappropriate in our judgment, for example, for the Federal Government to extend direct federal health care service to some groups of people and not to others. Where we have a legal obligation to provide direct health care services, as with the Indian Health Service, we feel that that obligation should be carried out because there seem to be no alternatives available at this time. But there is little merit and perhaps great mischief in setting new precedents for direct federal health services. Giving services to some groups and not to others, in our judgment, creates inequities, distorts the private health delivery system, and inevitably creates pressure to extend those direct federal services to other groups and perhaps to the entire population. We think that that's the wrong way to go. Taken to its logical conclusion, we would have a single system in the country, and of course it would be Federal.

However, there are roles for the Federal Government in health care that we feel are necessary and appropriate. There are activities that other elements of the public or private sector cannot do at all, or nearly as well. There we feel the Federal Government should continue to be involved. I'll go through these only because—as anybody outside of Washington and in many cases, many of us inside of Washington try to dissect out the many, many bills and positions that come out competing within Congress and within the administration and within the departments and the bureaucrats—it might be helpful to know what we would consider to be the rationale that we lay over all of these programs to see from our standpoint if they stay in or if they fall out.

We feel that the Federal Government should have responsibility to conduct basic health research and to stimulate new concepts of health care delivery. This work is vital if we're to improve the health care, and it must be adequately underwritten on a long-term basis, and only the Federal Government at this point can meet that requirement. But there's a caveat here, federal subsidization of demonstration projects must stop whenever a concept is found to be workable or on the other hand unworkable. Failure to observe this rule invites open-ended commitments to the future that create federal encroachment on the private system and an unending drain on the taxpayers, in many cases with little cost effectiveness.

Second, we feel that the Federal Government has a responsibility to regulate and to monitor health services to the degree that is necessary for meeting minimum standards of human needs and safety throughout the nation. There's a clear national interest that must be insured. On the other hand this does not mean, nor do we intend from our standpoint, that the Federal Government should do that. But we feel that we have a responsibility to see that in fact it occurs. It not only occurs in the health care industry, it has to occur in food inspection, product safety, medical devices, drug licensing, and many others.

Third, we feel that the Federal Government has a responsibility to insure that every citizen enjoys adequate access to health care. We feel that if there's a shortage of doctors there is a federal obligation to assist in relieving that shortage within the constitution. If an area of the country is without adequate medical care facilities, there is a federal obligation somehow to help insure that the people in that area receive the health care in some manner. If there are people who are unable to afford decent health services there is a federal obligation to pay for that health care

to the extent that's needed by each individual or family.

Now, these are the three main what we consider to be Federal Government roles in health care. It's not difficult to identify them. What's difficult is to determine the limits of federal involvement appropriate in each of these areas, and that perhaps is the case that exists between the administration and many of the committees of Congress, because where the federal role stops is seldom clear and often tempting to exceed. Yet the question is an important one since it involves both long-term ramifications to human health on the one hand and the future direction of the American Federal System of Government on the other hand. It is for that reason that there's debate over the federal involvement in health care in America and it has, as you well realize, the political domain. Last year, for example, a proposal was made that would radically have overstepped the appropriate federal role in health care in the administration's view, and I'm referring to a National Health Insurance Proposal which would have totally nationalized and federalized the health care system, with not only many congressional but many outside sponsors. In its place it would undertake to federalize not only the financing but also the delivery of health care in the country. The proposed legislation would have the Federal Government wipe out the existing private health insurance industry, collect all of the health care dollars in the country through taxes, and then pay the nation's doctor bills and hospital bills one by one or as best they can prove their own system. This measure in our judgment would be unwieldy, costly, and a wholly unnecessary bit of federal overkill. Yet in the judgement of the sponsors, the problems, as they viewed them, were so great that the temptation was too much to risk, and for the amount of support that they had from outside groups as well as from within Congress, you and I must realize that many people also view the problem to be that dramatic that it would justify this type of federal involvement. This proposal would also have proposed to allocate those dollars where they thought they should go. In other words if there was a surplus of doctors say in Trenton, New Jersey, and a doctor shortage in Rupert, Idaho, the federal dollars would be taken in effect from Trenton and put in Rupert in the optimistic hope that a surplus of doctors in Trenton would somehow resettle in Rupert where the dollars would be. This approach would obviously be dangerously disrupting, but it's the kind of typical Washington tinkering that creates problems rather than solving them.

I could be wrong, but I fail to see this year the same headlong rush in a National Health Insurance that existed in the last Congress, although perhaps it may be too early to tell. Perhaps this would bode well for the proposals that your association made, that the Health Insurance Industry has made, the ones that we've made, and the ones that many of the others who are involved in the private sector have made. Maybe the opportunity of time will allow us to work collaborately and rationalize something in the system that will meet the problems that the sponsors of the totally federalized programs have identified as well as those that we have.

Also on the administration's health care agenda this year before Congress are, and also some recently implemented things, I think a number of bills that I'll go through very quickly, I think lay out exactly why you and I have to have an involvement and a deeper involvement than we've had in the past. One of the first ones, and one that raises hackles in most medical societies that I have attended in the last several years, has been health maintenance organizations. But here again you and I have to take time to sit down and evaluate what the differences can be for the involvement of the federal government in a health maintenance organization. We have introduced in two successive Congresses in support health maintenance organization legislation on a demonstration basis, to see if it works as a competing alternative, not as a subsidized system. The difference we have with people who are sponsors of other health maintenance organization bills is that to insure that

they work they want the Federal Government not only to sponsor in many cases but to support them in such a way that we know that they'll work and that both providers and consumers will want to be involved. There is no question that you can make something operate if you put enough federal health dollars into it, but here is an easy delineation between what the federal role should be, and only by a close examination is your organization and the administration and the many other health professional organizations in this country going to be able to look past the title of something and see if the problem behind that title needs to be fulfilled and which piece of legislation is appropriately meeting that.

Another one that continually and I'm sure more so in the next few years will tend to create a higher secretion of adrenalin among the medical societies and the dental societies and the others is the professional standards review organizations, the PSRO's that were passed by Congress in the last year. A number of people see these problems in a lot of different ways. . . . As an example, today on the Senate floor there was a bill that's being debated that would have a Federal Health Care Quality Assurance Commission that would make the PSRO involvement in American Medicine very, very minimal by comparison. An attempt to delete that from that particular bill was defeated today 44 to 40, much closer than many of us thought we could get. I think it goes to show that there is amongst the Congressional body, and obviously they are reflecting the opinions of many people in the country, a question about how cohesive and how good our health care system is. There's where I think we have a joint responsibility to exhibit that we understand what the problems in health care are and that it's part of a pluralistic system. We can address them.

We feel that the Federal Government, as another example—and this will be my last—to draw a delineation between what needs to occur, is in the field of food inspection where the many billions and billions of meals that are prepared and pieces of food that are processed in this country, we have perhaps one or two botulism deaths every other year, I'm sure a record on a percentage basis that's unequaled by any other process that relates to the humans. Yet as a result of a single case in the last year there was an immediate federal push to increase the food inspectors some six-fold and to create a crash federal program to have a federal inspector on every food processing line full-time in this country. I think most of us know that that's not very cost effective and is rather a knee jerk, but when this occurred, in the judgment of the Congressional bodies, the food industry hadn't come forward and said, "We frankly had a processing mistake, but we think we can correct it, and we think that the federal inspection that exists today is probably adequate to see that it doesn't. We'll do a better job of self-policing." And until such time as they did that, the push to, as I say, increase the food inspectors on a direct basis manyfold continues. That again is where you and I share in having to be willing to address and understand our problems.

What I have attempted to demonstrate in a very few minutes, I think, is that there are some clear and, I would hope, some consistent rationales, and to underline the approach to health care, although I would grant from outside of Washington it may be very difficult to dissect these out, and the rationale has been applied, not just in the field of health, but we think for the next fiscal year throughout the President's budget.

There are some in Congress today who recently have been attempting to characterize these budgetary disagreements between Congress and the President as a vulgar "power struggle," as it was called by the *Washington Post*. One Senator said that the Administration's budget rationale was only a thin veneer to cover the budget-cutting efforts. Well, in the first place the Senator's facts were wrong. As I pointed out earlier, the health budget hasn't been cut. It's been increased by 3.5 billion dollars next year just in our department, but at the same time we laid all of

these 300 programs that I talked about earlier over those three rationales, and as a result of that many programs had to be terminated, some consolidated, some expanded. But I think that we've said many times that the disagreements about the size and the shape of the federal budget are welcome. They're part of the democratic process—such as I understood you indulged this afternoon—and they certainly add to the decision-making process. I suppose within that, up to the point of causing an additional tax increase, we'd have a great deal of flexibility. But irrational charges don't add to that democratic process. They detract from it. I can only say from the standpoint of the administration that we're committed to improving in meeting the needs of the people of the country, but we somehow have to rationalize it; we somehow have to make better use of the federal dollar; we somehow have to work with the private system to help them help themselves, to prove to your critics, to prove to our critics, and to prove to Congress that there is a better job that can be done and it can be done within limits which we can all accept.

I can tell you as a closing note that we're not committed to funding programs blindly, however good their intention if they don't work. If there's one lesson that can be drawn from many great society programs of the 1960's it's this: That good intentions aren't enough. That's not a slam at the programs of the '60's. They were programs of good intent. They were programs that were designed to meet specific needs. But in the end, it's performance that counts, and I would hope that our common goal would be instead change that works. I think we could say that nowhere are we more firmly committed to that precept than in the formation of public policy in health, and that doesn't come just from the federal level. But in seeking to determine the federal role in each of these cases of manpower and in research and in training and in financial access and quality of care we ask your understanding and encourage your involvement. And we do seek your assistance. We think that only by responsibly combining and evaluating the appropriate role, not only from the public sector but also from the private sector, can we meet that goal of increasing financial access, improving health care, and improving the health status of the people in this country, by building upon the system that you're a part of, lest we allow the problems to get so great that people decide that the only possible solution is to destroy that system and rebuild it in their own image. Thank you very much.

Dr. Albright: Dr. Zapp, we thank you very much for this report of what goes on in the health scene in Washington. We're deeply indebted to you. At this moment we are approaching the close of the program. I'm going to ask Dr. D'Elia to make his own closing statements. Bill, come up.

Dr. D'Elia: Thank you, Lou. I just want to take this opportunity to thank sincerely all the officers and physicians of this State, particularly the doctors in the various counties who gave so willingly and so well their time and effort to help me during the past year. I especially enjoyed visiting with you. Your receptions were good. It was a great experience. I'd like to thank Dr. Albright for a masterful job, Dr. Zapp for coming down here, my other friends at the table. Thank you again. Good night, and the music is ready to play.



President D'Elia



Auxiliary President, Mrs. Gandek, receives
Fellowette's Pin from President D'Elia



Officers' Dinner



Dinner-Dance honoring President D'Elia

THE AUXILIARY YEAR—1972-73

Saturday, May 12, 1973

Mrs. Charles Gandek: Thank you for giving me this opportunity to speak to you this afternoon. The members of your Auxiliary devote many hours sponsoring the programs which you have approved for us. But there are times when we wonder if you know what our programs are and if you support them.

Do you know that we have a LEGS Program? This is a *L*egislative *E*ffort *G*roup *S*ystem through which members are urged to get involved in political action. Recently we were asked to write our Congressmen to protest the HMO Bill S-14. Reports from Washington indicate that the thousands of letters received from members throughout the United States may have helped to bottle up the bill in committee. Have you written your congressmen recently?

We have a Community Health Education program involving nutrition, mental health, aging, and children and youth. This year in New Jersey we made a determined effort to raise the quality of health education in New Jersey schools. A committee met with the State Board of Education to urge the required use of properly trained health educators and a curriculum stressing nutrition and the teaching of bodily functions. The Health Education Chairman—Children and Youth—formulated a program to help each county consult with the county school superintendent concerning health education in local schools, and to plan a workshop for health educators. Passaic County held such a workshop this year. Have you inquired into your school systems to find out what kind of health education your children are getting in the schools they attend?

Do you know that last year the Auxiliary members throughout the United States raised over $700,000 for the American Medical Association-Education and Research Foundation, and that the women of New Jersey contributed over $13,000 last year. This year we have increased our contribution to almost $20,000. Have you helped us by donating to your medical school through the AMA-ERF Auxiliary Fund? Every penny you contribute is sent on to your medical school.

Do you know that you have a New Jersey Medical Student Loan Fund. You have asked us to make it a priority project and we have contributed the amount of $6,860.67 this year. Have you made a contribution to your own Medical Student Loan Fund? More funds are needed because freshmen in medical school need loans also and they are not now included in the loan program.

Do you know that our members are involved as volunteers in community health services, such as day care centers, eye screening clinics, Volunteer Friendly Visitors, diabetes and cancer detection clinics, and meals-on-wheels?

Do you know that you have a Society for the Relief of Widows and Orphans of Medical Men of New Jersey? We sometimes think you don't, for we often feel that we are knocking our heads against a stone wall when we try to help you obtain new members. This fund provides a quick, tax-free amount, approximating $1,000, to the widow of a member, and helps to provide an education for his children. We urge you to think of your loved ones and fill out a membership application today.

You have asked *us* to help you. We in turn ask *you* to help us help you. Thank you.

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Official Attendance Report

County	Delegates	Members	Total
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Bergen	37	29	66
Burlington	10	22	32
Camden	23	37	60
Cape May	3	3	6
Cumberland	5	7	12
Essex	57	123	180
Gloucester	5	4	9
Hudson	27	27	54
Hunterdon	3	2	5
Mercer	25	36	61
Middlesex	19	23	42
Monmouth	14	40	54
Morris	17	17	34
Ocean	7	14	21
Passaic	29	26	55
Salem	3	7	10
Somerset	7	12	19
Sussex	3	1	4
Union	27	28	55
Warren	3	3	6
Fellows and Officers	19	—	19
	350	509	859

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WARNINGS: If priapism or other signs of excessive sexual stimulatio develop, discontinue therapy. In the male, prolonged administration excessive dosage may cause inhibition of testicular function, w resultant oligospermia and decrease in ejaculatory volume. Use ca iously in young boys to avoid premature epiphyseal closure or pr cocious sexual development. Hypersensitivity and gynecomastia m occur rarely. PBI may be decreased in patients taking androge Hypercalcemia may occur, particularly during therapy for metast breast carcinoma. If this occurs, the drug should be discontinued.

ADVERSE REACTIONS: Cholestatic Jaundice • Oligospermia and d creased ejaculatory volume. • Hypercalcemia particularly in patie with metastic breast carcinoma. This usually indicates progression bone metastases. • Sodium and water retention. • Priapism • Vi zation in female patients • Hypersensitivity and gynecomastia.

DOSAGE AND ADMINISTRATION: Dosage must be stricly individualize as patients vary widely in requirements. Daily requirements are be administered in divided doses. The following chart is suggested as average daily dosage guide.

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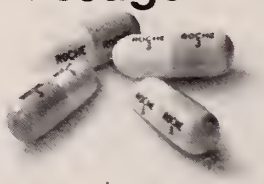
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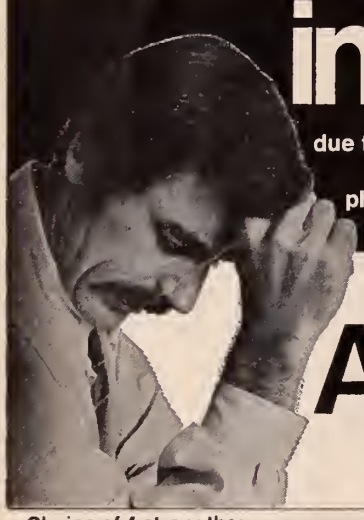
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References: 1. Montesano, P., and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964 3. Tiseff, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Heilman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. Farris, E. J., and Colton, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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Opinion & Dialogue

"Prescription drugs – who should determine the maker?"

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Clifton J. Latiolais
President
American Pharmaceutical Association



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"Too many doctors are indifi ent to the economic consequence their decisions." So stated a recer issue of *Medical News Report* (De cember 4, 1972), an independent weekly newsletter published by for AMA Chief Executive F. J. L. Blasir game, M.D.

Doctor, are you indifferent...?

In discussing an anticipated crease in Blue Shield rates, Dr. Bl ingame's newsletter had this to sa

"In general, it can be said, M have given the impression they are not particularly concerned with th increase in cost of health care to tl patients...

"True, an MD's training is pri marily scientific, but in the real wc of practice, all of his scientific dec sions have a price tag, or an econo impact. The economics of health c beckon the practitioner's attentior Concern for economics of medicin

When the pharmacist recom- mends that a drug product other th the one ordered be dispensed, the prescriber invariably permits the change when he feels the best inte ests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is nec sary for the prescriber to know that the change is being contemplated, and to be in a position to consent o demur. Without that opportunity, tl unilateral decision of the pharmaci made in the absence of clinical knc edge of the patient, could expose h to needless risks, and in addition, jeopardize the relationship betwee the professions of Pharmacy and Medicine. In my view, there is noth in the pro-substitution argument th offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowled about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degre puts him at a disadvantage. Most often, a practicing physician will ne expert knowledge of no more than 2

Advertisement

uld be an obligation of medical ctice...

"Medical societies ought to con- t continuing campaigns to point the substantial savings that could e ealized thru deductible insurance protection for catastrophic ill- s. At the very least, they should, in patients' interest, question the ics of any insurance organization raises health care costs by forc- policyholders to buy insurance may not need or want and prob- won't ever use.

"Too many doctors are indiffer- to the economic consequences of r decisions. Too many, for ex- ple, habitually hospitalize patients the convenience of the MD. It's sense to deny such habits exist...

"Doctors, thru their medical so- ies, have unhesitatingly appealed eir patients for support in the t against government interference the private practice of medicine. d the public in the past has re- nded. It's time the American Med- Association and state and local dical societies paid off the debt by cisive action to hold down the cost medical care."

st of Drugs

Insurance rates and hospital arges are only two factors in health care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

---

c30 drugs that he selects to treat the ajority of conditions encountered in practice. Moreover, the physi- n's choice of a specific brand is sed on his knowledge of the pa- nt's medical history and current ndition, and his experiences with e particular manufacturer's oduct.

Some substitution proponents ve argued that the dispensing of a escription is a simple two-party nsaction between the pharmacist d the patient, and that a substitut- g pharmacist may avoid even a chnical breach of contract by simply tifying the patient that he is making e substitution. I would judge that w courts would be sympathetic ward a pharmacist who substituted ithout physician approval and who ndertook a legal defense that seeks make the patient responsible for e pharmacist's actions.

educed Prescription Prices?

Substitution advocates are ggesting to the consumer, and par- cularly the consumer activist, that educed prescription prices could llow legalization of substitution. /e have seen absolutely no evidence justify this claim. To the contrary, xperience in Alberta, Canada, where ubstitution is authorized, suggests the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

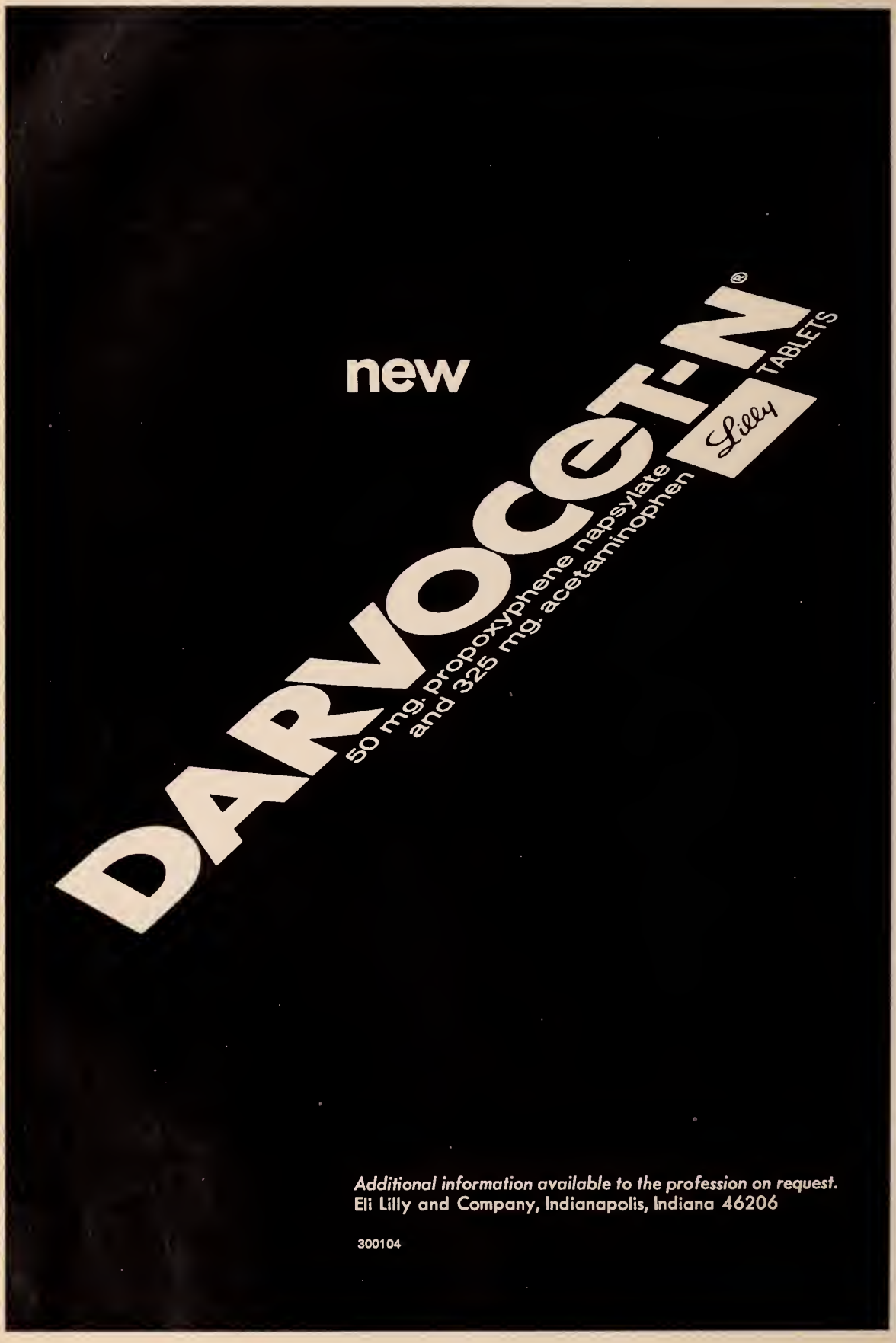
Summary

In short, what the American Pharmaceutical Association advocates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

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EDITORIALS

A Brake on Pharmacologic Progress

No one, of course, is opposed to efforts to make medications safer and more effective. However, it may be that such sincere and well-intended efforts are actually depriving many of our patients of drugs which are available in Europe where there is no evidence of any serious harm produced by such medications. The FDA now demands detailed biochemical, physiological, and metabolic studies, which stretch out the time before a drug can be distributed and which greatly increase the cost of producing new medications (and, therefore, the cost to the patient). This may drive out of their businesses the less prosperous and smaller pharmaceutical manufacturers. The financial well-being of drug companies is not, of course, a reason for permitting the distribution of unsafe or ineffective pharmaceuticals. But the obsessive pursuit of no-risk medication is likely to grind to a halt any innovation in or progress in pharmacology. You can always find one experience which suggests an untoward result with any medication.

If carcinoma of the bladder of a mouse is found once after a mouse has been given a hundred times the recommended therapeutic dose of the new drug, so that the chance that the medication can be carcinogenic is, perhaps, one in a million (and then only with enormous doses), there would seem to be no sensible reason for denying Americans the availability of an otherwise helpful medicine. Let it be noted that in the U.S.A. most new pharmacologic discoveries came out of the laboratories of private industry, not universities or government agencies. Much of the harassment of private, industrial, drug-making laboratories comes from well-meaning and zealous critics who simply are not qualified to make such judgment. It is also true that this enthusiasm for monitoring drug research often rests on the assumption that, left to their own intelligence and good sense, most physicians are too naive to make the necessary judgments of safety or effectiveness. Drug abuse, in practice, comes not from physician-prescribed medications but from black market or irregular sources. The availability of emotion-influencing medication is often the salvation of a depressed or agitated patient, a suicide-preventer, and a stabilizing influence in the life of an over-agitated patient. It is probably true that the well-meaning inflexibility of FDA regulations is actually retarding pharmacologic progress in the U.S.A.

Teach Me, I Dare You!

During the last few decades there has been a resurgence of interest in the teaching function of the physician. Directors of medical education are being appointed in even rather small hospitals. Our own Medical Society has, through the company of scholars known as the Academy of Medicine, developed its special teaching arm. Medical publications abound in announcements of lectures, seminars, symposia, and courses. However, in line with the trend which has resulted in creating instant coffee, automatically cooked hamburgers, and prepackaged mashed potatoes, we seem to be looking for prepackaged, one-shot medical education.

Graduate programs are often advertised as being practical or "clinical"—the implication being that the course will emphasize a how-to-do-it formula instead of "wasting time" on background, historical, basic physiologic, or anatomic factors. The student (graduate or undergraduate) wants to know what medication to use, in what dose, and by what route. He is bored with structural formulae of the chemical compounds, or abstruse aspects of pharmacology and pharmacognosy. Furthermore, our ingenious inventors have developed a variety of "teaching machines" and "programed learning devices." So, teaching methods, like so much else in modern life, have become mechanized. Not only that, but with

the current trend toward pupil power in the schools, tenant power in apartment houses, and consumer power in trade legislation, the new cry is "relevance." The teaching must be relevant to the needs of daily practice. More and more the graduate programs begin to resemble vocational school courses, where teaching the technic of handling a disease is somewhat like teaching the student how to repair an air conditioner. It is as if the student sat back in his chair in the lecture room and said: "Teach me, I dare you."

The Physician and Price Controls

The American Medical Association has protested vigorously against keeping physicians under federal regulation in the economic controls program. A largely voluntary set of wage-price controls was substituted for all segments of the nation's economy except food, health care activities, the construction industry, and interest and dividends.

John R. Kernodle, M.D., Chairman of the AMA Board of Trustees, warned that such discriminatory treatment well could result in health care support personnel leaving the field.

"Controls are relaxed in other areas, yet the discrimination against physicians and some three million others who serve America's health needs is now even more sharply focused," Dr. Kernodle said in a statement. "A very real possibility exists that there will be a flight of allied, ancillary, and support personnel from the health field, jeopardizing the quality of care being delivered." He further pointed out that, "even though the regulations as applied to health care were clearly discriminatory," the AMA had urged physicians to cooperate and they had done so with a result that their fees nationwide had increased by only 2.7 per cent since August, 1971, when Phase I began. This compared with 4.3 per cent for the consumer price index, 6.2 per cent for a semi-private hospital room, and 14 per cent for legal services. Noting that controls never were imposed on lawyers or other self-employed professionals, he said that physicians now might have to reconsider their attitude of cooperation.

"Since its inception, we in medicine have made every effort to cooperate with the government's program," Dr. Kernodle said. "While the Lords of Labor walked out, we remained in the program and tried to make it work in the public interest. The results speak for themselves.

"We have received very little cooperation in return . . . Thirteen months ago, we urged physician compliance. In light of the . . . record, we shall now have to reconsider."

Dr. Kernodle has sent the following letter to President Nixon:

"The American Medical Association has applauded your Administration's efforts to stabilize prices and wages for the economy. The Association has supported the over-all objectives of the Economic Stabilization Program and actively cooperated with the Cost of Living Council through the Health Services Industry Committee in the application of price controls on physicians' fees.

A look at the physician component of the Consumer Price Index gives an example of the effect that "voluntary compliance" can have in curbing inflation. As a result of this Association's activities, physicians' fees rose only 1.7 per cent under Phase II. This constitutes one-third the rate of increases prior to the Economic Stabilization Program. In this respect, we have surpassed the original expectations of the Cost of Living Council, which called for halving the inflationary rates prior to Phase I.

"In view of our demonstrated success during the past year, you can imagine our dismay at the announcement of plans for Phase IV. Although most of the economy is now expected voluntarily to adhere to the general guidelines of the Cost of Living Council, the medical profession has been placed under *mandatory* regulations. Indeed, the medical profession has once again been singled out under special controls. The physicians of America will not accept such discriminatory treatment. This profession must not become the victim of efforts to curb inflation in the more expensive components of the health care industry, which due to their internal financial structure have been unable to decelerate increases in their prices.

"The record of the past year clearly demonstrates that physicians are able effectively to control their fees through voluntary action. Physicians' fees have *not* been an inflationary factor in health care costs."

ORIGINAL ARTICLES

Generating more physician manpower is a many-sided venture with some usually, seldom-thought-of angles.

Physician Manpower: The Issues

Stanley S. Bergen, Jr., M.D./Newark*

If one were to conduct a public opinion poll and ask respondents their opinion as to the need for additional physician manpower, I am sure that a large proportion would assert the need for more doctors. Daily, the public suffers from the problem of not being able to obtain the services of a physician when, where, and under the conditions that they have been informed are ideal for good medical care. Most MD's would probably join with the general public, in stating a need for more physician manpower. However, as pointed out by Wilson,[1] "Our understanding of the physician manpower market is too limited to provide guidance from a hard data base. We must rely alternately on consensus." Matlack[2] has called our attention to the diversity of factors that have a bearing upon this problem. Increased enrollment, new medical schools, accelerated programs, integrated premedical and medical programs, advanced standing admissions, curriculum reform, multiple tracts, and core curriculum are some of the items that must be taken into account as we try to determine the need for more physicians and more medical schools. In addition, there is the traditional problem of the partition of time both of faculty and practicing physicians between health care delivery, education, and research. To the layman who is unable to obtain the services of a physician when needed, or who has faced the long wait in the doctor's office, or who has been forced to seek out the health care potential of a busy community hospital emergency room, there is no doubt there is a physician shortage. On the other hand we must not confuse the problems of increased production with increased need and increased productivity. There is a great difference between production, need, and productivity. All three can have a great effect upon the number of physicians practicing or available to deliver health services to the American public, and yet each dictates a different course of action. If one is to accept the statistical methods utilized to project shortages in health manpower occupations, methods that have taken into account, census, supply, demand, maximum and minimum national health insurance impact, and other pertinent factors, then the projected shortage of physicians in New Jersey by 1975 has been estimated to be at least 1,100 practitioners and, at greatest estimation by 1985, almost 4,000 physicians[3]. If the maximum estimate is accurate we have a tremendous challenge before us, if we are to close this gap in the next twelve years.

The Parts of the Problem

Many studies have been performed in the last fifteen years, all indicating a need for more physician graduates from our medical schools, all differing widely in their estimation of this need. The Bayne-Jones Report[4] in 1958 indicated a need for 8,700 graduates per year by 1970. The Bane Report[5], which has become a milestone document, indicated the need for 11,000 graduates by 1975. The Howard Report[6] recommended the graduation of fifteen thousand physicians per year from our medical schools by 1980. Most recently the Carnegie Commission Report of Higher Educa-

*Dr. Bergen is President of the College of Medicine and Dentistry of New Jersey.

tion and the Nations Health,[7] has indicated the need to increase the number of entrants from 15,300 by 1976 to 16,400 by 1978. Each report has been based on various methods of statistical analysis and indicated the need for additional medical schools to assist in closing the gap. Wilson[1] has provided us with a compilation of the Department of HEW estimate projection of physician needs with this figure currently being placed at a deficit of 50,000 practicing physicians.[8] To provide validity for these statistics and the studies that have produced them, we must make a decision as to what goal we are attempting to reach. Do we wish to attain the national average of 150 physicians per 100,000 population? Are we aiming to meet the ratio of more highly physician-populated areas such as the Middle Atlantic and New England? Are we satisfied in accepting the averages now available in the more rural portions of our country? On the other hand do we believe the United States, as noted by Senior and Smith,[9] must meet the ratios provided by the nine countries that rank ahead of us in physician production and availability. It is critical that this goal be established. In making this decision we must be well aware of the costs. There will be added costs of the educational process as we create new buildings and new medical schools or expand current facilities. It is the in-hospital factor in medical care that adds greatly to the expense of this commodity. Ambulatory services do not have the same impact on the health care dollar cost and thus all goals must be established and carefully delineated. Systems and mechanisms must be changed concurrently with manpower projection and expansion.

Besides projections for current needs, we must take into account such factors as attrition and the pool of manpower available. In a recent study initiated by the New Jersey Department of Health[10] in three counties in our State, the number of physicians and ratio of physicians over the age of 50 years were calculated in four categories; general practice, internal medicine, surgery, and pediatrics. This study notes that in some counties a significant attrition based on age alone can be expected in certain categories of physician manpower in the years ahead. Such attrition, unless balanced by an influx of new manpower, could lead to serious problems for those counties and potentially the state as a whole.

We must also consider the problem of distribution. Unequal geographic distribution would indicate that some of our counties are more than adequately served while others are in significant need of additional manpower. Nationally, the same distribution problem holds true with physicians being attracted to those areas which are more desirable economically and more desirable for family educational needs and other resources. The more rural portions of the country and the inner city urban areas continue to be shunned as private practice locations. Distribution between specialties is also significant since there are some specialties which are not attractive to new medical school graduates while others continue to attract a surfeit of able candidates. The need for greater attention to primary care physicians has been noted by many authors with the most significant reports being those of Millis,[11] Willard,[12] and Coggeshall.[13]

Other factors that must be considered in our projection are the impact of foreign graduates both as housestaff trainees and as practicing physicians and the impact and potential distribution changes that may be manifest by the increased enrollment of minority disadvantaged students.

Other Problems

The community (public) must join with medical leadership to make decisions as to whether we need more physician graduates and/or more medical schools. Certainly, if it is feasible to expand our current facilities to accept more candidates, this would seem to be the cheaper course to follow. On the other hand, it may not be conducive to the educational process to expand our current schools and their facilities beyond a critical point as yet undetermined. Therefore, we will be faced with a need to continue creating more medical schools if some of the projected needs are proved to be accurate and require fulfillment.

Senior and Smith[9] have developed compelling evidence that the addition of physicians has not had a significant effect on mortality, morbidity, or other critical measurements of population health. Thomas[14] calls our attention to the need to be wary of an over-estimation of need based on an attempt to provide medical care for all whether they require such care or not. On the other hand, we must realize that there are many segments of our population who are now unserved or underserved. While none of us wishes to deny that the private practice of medicine and the solo practitioner has for many years provided quality medical care to his patients, many individuals have gone without medical care due to the problems of manpower supply, available facilities, and economics. As we observe a dramatic change in our delivery system away from the solo practitioner based in his office toward a system developed around health care facilities such as our hospitals, we must adapt our manpower needs to relate to these changes. Everyone may not be able to have his own private family physician. Other programs may provide for this type of care. As we observe the transition from the solo practitioner to the group or team approach there will be an increasing need, as noted by Millis[15], to develop goals in education and service. Castleton[16] has suggested a moratorium on the development of new schools until such a policy can be developed. Wilson[1] has indicated the need for a commission to study the problem and bring forth recommendations both as to educational needs and manpower needs.

The Parts of the Solution

It is obvious that better allocation of the time spent in direct patient care activities will be needed. The administrative or so-called "paper work" burdens now placed upon this highly qualified and most expensive commodity, the physician, must be reduced. Similarly, the distribution of physician manpower to previously unserved or underserved areas must be approached directly and solutions must be found. The National Health Service Corps is one attempt to address this issue.

The tremendous burgeoning of allied health occupations over the last twenty years has brought us to the realization that there are many other hands that can help in the delivery of health care. The team approach that has been espoused by Pellegrino[17] and other medical educators must be considered as at least one potential solution as we incorporate such categories as the physician's assistant, pediatric nurse practitioner, and so on, into the health care delivery mechanism. We must guard against over-production of physicians so that we do not squeeze the balance in the wrong direction. Senior[9] notes that a positive balance could have an adverse economic effect by increasing the need for health services merely to utilize fully the manpower available.

Medical schools throughout the country have addressed themselves to the problem of educational commitment and developed demonstration projects, shortening the medical school curriculum to three years, shortening the total undergraduate and medical school curriculum to six years, and reducing the time requirement of graduate education in the internship and residency period either by eliminating the internship requirement or shortening the residency period. All these experiments will require careful observation and evaluation if we are to determine the most productive pathway to increase our health manpower pool. Unfortunately, many of these projects have overlapped and are overlapping, thus, I wonder whether the multiplicity of superimposed changing factors may prevent an accurate evaluation of the statistical results.

As we attempt to provide services for both the unserved and underserved of the past, we must evaluate the impact that will be felt by the enactment of a national health insurance program for our country; an impact which may or may not mirror the effects that we have seen from the Title 18 and Title 19 programs of the federal government, programs that in many cases merely expanded health care dollar costs without significantly improving community health.

The Needs for New Jersey

We all realize that New Jersey is far behind in the area of medical education. The most aged element of our educational system is of less than twenty years in duration. Let us not panic in an attempt to solve this apparent crisis, but rather continue with the orderly development of our two existing medical schools. These two schools should be carried to maximum productivity as fast as possible within the limitation of facilities, ability to recruit quality faculty, and provide quality educational experiences. The College of Medicine and Dentistry of New Jersey must continue to organize a coordinated educational system in cooperation with affiliated community hospitals. It must develop significant graduate educational programs complemented by educational programs for the development of allied health professionals.

This system of medical and dental education must also include a large segment of continuing education for practicing physicians to assist the physician in maintaining adequate levels of competence, health care delivery potential and to assure the maximum productivity of our currently available resources. The College must serve as a state-wide facility, and extend its influence to the delivery system in addition to the educational area. The feasibility study for a third medical school in the southern portion of our state must continue. The decision concerning the creation of this school will be based not only upon total physician needs but also upon the geographic distribution of our facilities and their impact on the delivery system, urban problems, and physician continuing education. Careful planning will continue to be needed for many years as New Jersey attempts to "catch up" with the need for adequate educational facilities. We must all guard ourselves against the overshoot phenomenon recently experienced in the areas of teacher, engineer and space science profession education.

A Final Warning

Our schools must not become preoccupied with a "numbers game." To direct ourselves toward production of more physicians alone would lead us down the path of potential disaster. While we must be responsive to the needs of the people of New Jersey and to the national needs for additional health manpower, the medical school is more than a production mechanism. Quality, not quantity alone, must be considered. The medical schools must remain as reservoirs of knowledge, the seat of research, and an instrument of change while providing a home for the proved and accepted.

As with all educational facilities we must maintain our goal of providing primarily for the generation of new knowledge and the production of qualified, competent physicians.

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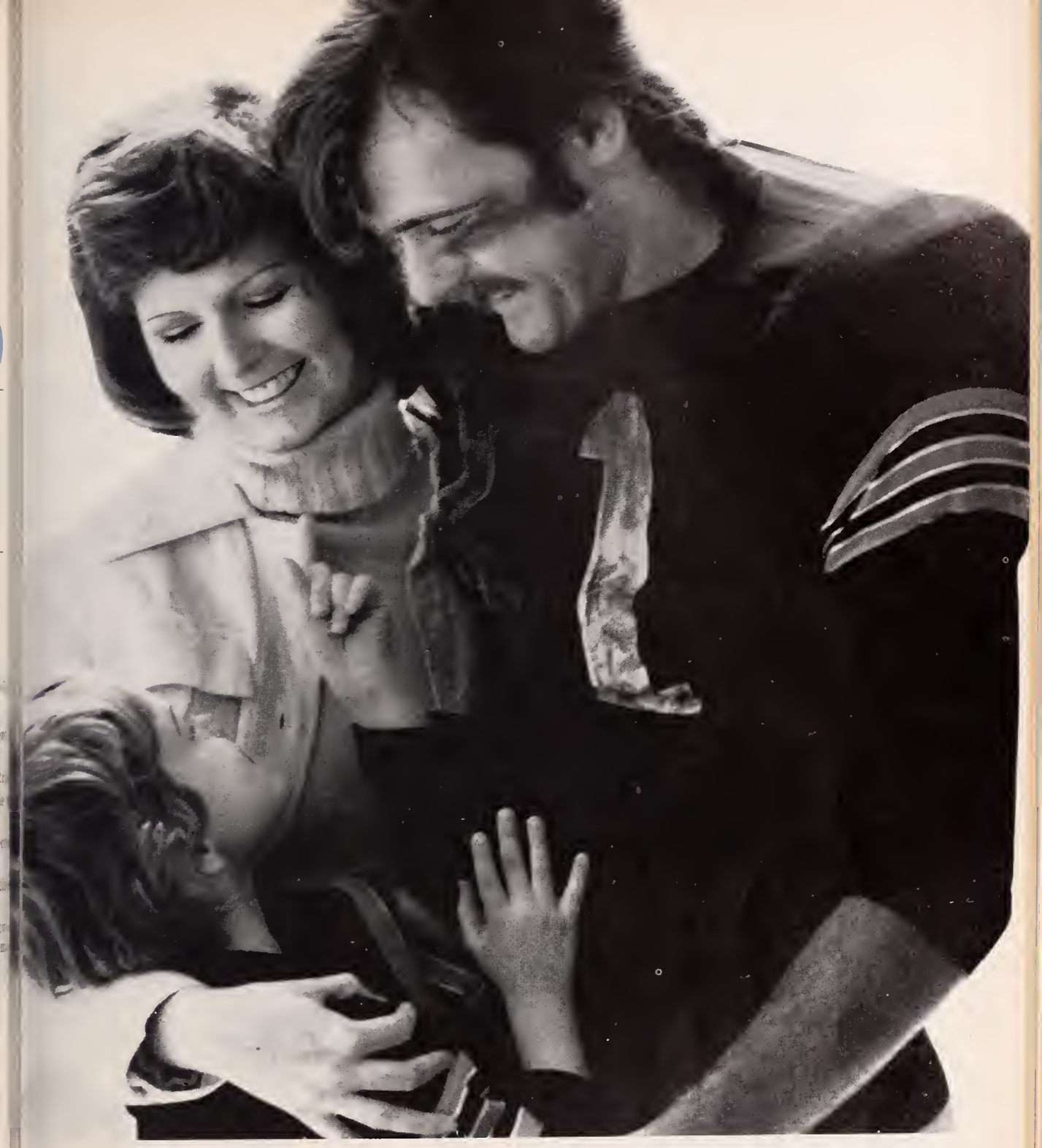
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Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to those pregnant patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. Exacerbation of moniliasis may occur. In amebic liver abscess, aspirate pus during metronidazole therapy.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia*, exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, pruritus, dys cystitis, a sense of pelvic pressure, dyspare fever, polyuria, incontinence, decreas libido, nasal congestion, proctitis, pyuria darkened urine have occurred in patient ceiving the drug. Patients receiving Fl may experience abdominal distress, na vomiting or headache if alcoholic bever are consumed. The taste of alcoholic b ages may also be modified. Flattening o T wave may be seen in ECG tracings.

Dosage and Administration: For Tri moniasis. *In the female:* One 250-mg. orally three times daily for ten days. Co may be repeated if required in especially s born cases; in such patients an interval of to six weeks between courses and total and ferential leukocyte counts before, during, after treatment are recommended. Vagina serts of 500 mg. are available for use, par larly in stubborn cases. *When the vagina serts are used,* one 500-mg. insert is placed



ne vaginal vault each day for ten days and oral dosage is reduced to two 250-mg. tab- daily during the ten-day course of treat- t. Do not use the vaginal inserts as the sole of therapy. *In the male:* Prescribe Flagyl when trichomonads are demonstrated in urogenital tract, one 250-mg. tablet two s daily for ten days. Flagyl should be taken oth partners over the same ten-day period n it is prescribed for the male in conjunc- with the treatment of his female partner.

Amebiasis. *Adults:* For acute intestinal biasis, 750 mg. orally three times daily 5 to 10 days. For amebic liver abscess, 500 50 mg. orally three times daily for 5 to 10 s. *Children:* 35 to 50 mg./kg. of body ght/24 hours, divided into three doses, ly for ten days.

sage forms: Oral tablets 250 mg.
Vaginal inserts 500 mg.

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Iatrogenic Ileus Secondary to Medication*

Robert K. Spiro, M.D. and Roman M. Kysilewskyj, M.D./Bloomfield

The side effects of drugs are manifold. The following case report points out one which is not too common: intestinal ileus. This, when it occurs, is a significant problem. If it can be relieved in a simple fashion without surgery, the patient and the physician are particularly happy.

A fifty-five-year old man was admitted to The Mountainside Hospital in Montclair complaining of abdominal pain for four days with severe vomiting for one half day. The pain had begun gradually four days before admission and was mainly epigastric and mid-abdominal. In spite of his distress, he had continued to work, but was forced to stop on the day of admission because of severe vomiting and abdominal pain. He is an accountant for a pharmaceutical firm. He went to the Employee Health Department. X-rays there were interpreted as showing intestinal obstruction of large and small bowel. White blood count was 15,800 cells with 91 per cent polymorphonuclear cells. The employee health physician advised him to see his own physician, who admitted him to the hospital directly.

This patient has had emotional problems for about twenty years. A working diagnosis of schizoid personality and depressive reaction has been made. He has had psychiatric therapy, electric shock and also drugs. At the time of admission, his medication was Stelazine,® 2 mg. t.i.d., Ritalin,® 10 mg. t.i.d. and Cogentin,® 1 mgm. t.i.d. He had a transurethral resection of the prostate at another hospital two months ago for prostatic obstruction. No malignancy was present. The other details of his past history were not specifically pertinent.

On admission to the hospital, he was an alert man complaining of abdominal pain and nausea. He was acutely ill. Blood pressure was 140/90, pulse was 96 per minute and temperature was 99.4. Significant findings were limited to his abdomen. It was distended and the bowel sounds were decreased. There was tenderness in the epigastrium and in both lower quadrants. There was brown stool in the rectum. Diagnosis on admission was intestinal obstruction.

Laboratory data on admission included a urinalysis with a specific gravity of 1.023, a trace of protein and a 2 plus acetone and the microscopic examination showed 1 to 5 red cells and 75 to 100 white cells. The white count in the few hours since he had been at work had risen to 18,000 with 94 per cent polymorphonuclear cells. The hematocrit was 47.7 and the hemoglobin was 15.9 Grams.



Figure 1—The marked distension of both large and small bowel consistent with an ileus is evident.

X-rays revealed a negative chest and significant distension of both the small and large bowel. (Figure 1) The radiologist felt that this distension could be due either to a fecal impaction or that he may have had an obstructive process such as a carcinoma. Paralytic ileus was also considered.

Blood chemistry values the evening of admission were: pH 7.42, CO_2 content 27, chlorides 90, sodium 137, K 4.2, and urea 19.5.

In view of the unusual x-ray findings and the presence of the stool in the rectum, the patient was given three

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enemata which produced brown stool. A barium enema was done, (Figure 2) which revealed no point of obstruction, but a marked dilated large and small intestine believed to be the result of the medication the patient was taking. The working diagnosis was iatrogenic intestinal ileus and the direction of therapy was to support the patient until his own intestine functioned to relieve the ileus.



Figure 2—Enormous loops of large and small bowel with no evidence of colon obstruction fit the picture of ileus.



Figure 3—The general pattern of the bowel has returned to normal. Some residual barium in the colon is seen.

The patient received parenteral fluids of 1,000 cc 5 per cent D/W alternating with 5 per cent D/1/3 normal saline each eight hours. A nasogastric tube was passed and attached to low suction.

In view of the marked distension and leucocytosis (suggesting intraperitoneal irritation), the patient received a gram of Ampicillin® piggy-backed in 150 cc 5 per cent D/S to each 1,000 of parenteral fluid. Sparine,® 25 mg intramuscularly, was prescribed every four hours for nausea and vomiting.

The following day, the SMA-12 was normal and the urine culture negative. The white blood count had dropped to 7,000 cells with a normal differential. Enemata were productive of stool and the abdomen softer and flatter. The input and output were well maintained parenterally.

The next day he began oral intake of fluids and was switched to Polycillin® 250 mgm, four a day. White blood count dropped to 5,800 cells with 80 per cent polymorphonuclear cells and the patient felt well. X-rays on this day showed an essentially normal abdominal intestinal pattern. (Figure 3) He improved during the day and went home well the following morning, comfortable and with a normal temperature. He was to consult his psychiatrist regarding medication for the future.

Assessment

The development of iatrogenic ileus or intestinal obstruction has been reported from many agents, including the following:

Antacids, so commonly used in ulcer therapy have caused obstruction.[1] Coumadin[2] resulting in subserosal or intramural hematoma has done the same and has also produced intestinal ileus.[3] Nortriptyline, an antidepressant has led to ileus.[4] Particular note of this is important considering the wide use of antidepressant drugs today. Hydrochlorthiazide potassium therapy has resulted in obstruction secondary to the ulceration produced by the drug[5] which may subside when the administration is stopped.[6]

Formulation

In this case the Cogentin® acted as an atropine-like drug blocking the parasympathetic contractile stimulation to the intestine, with the subsequent development of ileus. The rapid return of function of the intestine was evident within one-half day after the medication was stopped.

Summary

The relationship of intestinal ileus and obstruction to drugs is pointed out. A case of ileus related to Cogentin® medication is presented. No surgery was needed to relieve the ileus. The critical importance of knowing the drugs a patient is taking at any time and which may influence his therapy cannot be overstated. This information can be obtained only from a carefully elicited history of the patient's total health picture.

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1218 Broad Street

Teaching Two-Year Olds to Swim

Teaching very young children to swim is of doubtful value in protecting them from drowning, says an article in the May 1973 issue of *American Journal of Diseases of Children.*

Even if the two-year olds learn to "swim," the level of skill is inadequate to cope with most accidents of falling in the water, says Albert B. Craig, M.D., a physiology professor at the University of Rochester.

"Parents may have a false sense of security when their young one graduates from a learn-to-swim course," declares Dr. Craig. He urged careful supervision of the child and wearing of lifejackets as much better preventive measures.

"I doubt if the fully-dressed child would be ready to cope with falling in a pool or going overboard from a boat towing a water skier," he says. However, he adds, learning to swim is the initial step to prevention of drowning, suggesting that by age seven or eight most children have the physical development and coordination to benefit from good swimming instruction. "Some children will like swimming, some will not, and others will be terrified by the thought of going in the water."

Basic swimming skill is only the first step in water safety, Dr. Craig writes. There are other safety problems related to boating, water skiing, and under-water diving. Diving, with or without the use of self-contained underwater breathing apparatus (Scuba) requires training. Panic can occur as easily at 10 feet as at 100 feet down in the event of trouble with the swimmer or his apparatus. Excellent swimmers can run fatal risk when they attempt to set records for swimming underwater. The problem is hyperventilation, taking in a big, deep lungful of air before submerging to try to swim across the pool and back underwater. The author has cataloged 52 cases of "shallow water blackout." About three-fourths occurred in well-guarded pools and many resulted in death. The accident occurs almost exclusively in excellent swimmers trying to exceed their own or their peer's distance or time record underwater. During breath holding there is a marked increase in the partial pressure of carbon dioxide within the body. This pressure tells the swimmer to surface. But hyperventilation masks this symptom, and the swimmer can actually pass out without experiencing even a moderate urge to breathe, he says.

If the youth trying for underwater distance is good, he will pass out. If he is lucky, someone will see him on the bottom of the pool and pull him out quickly. There is at least an even chance that he will lie there for a few seconds more, and die.

Here is one of the rarest anomalies ever reported. Only two similar cases have been previously recorded in the world's literature.

Anomalous Left Pulmonary Artery

Arising from the Ascending Aorta

**Robert Brill, M.D.,
Evalynne G. Velez, M.D.,
and Patrick M. Colagiuri, M.D./Passaic***

The combination of anomalous left pulmonary artery, arising from the ascending portion of a right-sided aorta plus a patent ductus arteriosus is rare. Only two similar cases have been previously described.[1, 3] Most cases of anomalous absence of the left pulmonary artery show an associated tetralogy of Fallot, or other defects such as patent ductus arteriosus, ventricular septal defect, atrial septal defect, aortico-pulmonary window, and co-arctation of the aorta. In almost all cases of such absence, the blood supply of the affected lung comes from the bronchial arteries or a vessel coming from the aortic arch.

Of the similar cases, one demonstrated an absent left pulmonary artery, a right-sided aorta and a patent ductus arteriosus with right-to-left shunt.[2] Here, the anomalous artery was seen through cineangiography as a "large bronchial artery from the left side of the ascending aorta." There was no operation or postmortem done to confirm this.

The second case was described by both Pool, *et al.*[1] and Swann, *et al.*[3] This presented an absent left pulmonary artery, right-sided aorta, and ductus arteriosus with left-to-right shunt confirmed by surgery.[1, 3]

The following case is presented in detail because of the rarity of this anomaly.

A female infant was born of a full-term, apparently uncomplicated pregnancy. She was a first child with a birth weight of 6 lbs., 8 oz. No abnormalities were noted at birth and no problems recorded while the child was in the nursery. She was discharged on the fifth day of life as a normal newborn female. At six weeks of age, a heart murmur was noted and the child was referred to a pediatrician.

Seen at two months of age, the baby weighed six lbs., 15 oz. She was non-cyanotic, with a grade IV systolic murmur heard over the entire precordium. The femoral pulses were weakly palpable. The diagnosis was congenital heart disease.

Between the second and third months of life it was noted that the baby became dusky when crying. Also a precordial bulge was evident and now, in addition to the murmur, there was a systolic thrill at the third left intercostal space para-sternally. The heart rate was 166/min. with accentuation of P_2. Her weight was now 7 lbs., 12 oz. Roentgenograms showed that the heart was enlarged with increased vascularity of both lungs. A right aortic arch could be identified on review of the chest x-ray after post mortem (Figure 1). Electrocardiogram showed right ventricular hypertrophy and strain.

At three and a half months, the infant had an upper respiratory tract infection and was treated with an antihistamine, a decongestant, and tetracycline. Two days later, she showed increased irritability, intermittent cyanosis, and respiratory distress. At this time the child was moderately cyanotic with flaring of the alae nasae and subcostal retractions. The liver was two finger-breadths below the right costal margin; heart rate was 194; lungs were clear. The murmur and thrill noted before were still evident with the precordial bulge. The child was hospitalized, but died one-half hour after admission. Portable chest x-ray taken prior to death showed decreased aeration of both lungs, more pronounced on the right, and uniform enlargement of the heart.

Post-Mortem Examination:

The body weighed 3,600 Grams and measured 46 cm. in length (average normals would be 5,600 Grams and 56 cm. respectively).[4] There was marked cyanosis and no pedal edema.

The heart and lungs together weighed 210 Grams. For a three and a half month old infant normal weight

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Figure 1—X-ray at age three months showing right-sided aorta and enlargement of the heart with greater prominence of the right chambers.

would be 81 Grams.[5] The lungs showed congestion and edema. The right lung presented only two lobes. This was the only anomaly other than those in the cardiovascular system.

The liver and spleen were congested and weighed 200 and 25 Grams respectively. Normals would be 151 and 11 Grams for a three and a half month old infant. Except for congestion, the other organs were unremarkable.

The heart was large and its general outline was globular due to prominent right ventricular hypertrophy. The right atrium was dilated; it showed endocardial opacity and muscular hypertrophy. It received the superior and inferior venae cavae. When examined from the left side, the septum secundum completely covered the aperture, but there was probe patency permitting passage of an instrument 0.4 cm. in diameter. (Figure 2)

The right ventricle was dilated and hypertrophied, measuring 0.7 cm. There was marked prominence of the trabeculae carnae and slight endocardial opacity. The pulmonary ring measured 3.1 cm. in circumference, and presented the usual three cusps with increased opacity.

The pulmonary artery originated from the conus and pursued its usual course upward to the right and at the hilum of the right lung divided into two branches, one for each lobe. The pulmonary trunk measured 2.6 cm. in circumference just above the cusps. Its length was 2.9 cm. before it divided into two right pulmonic branches, each 0.7 cm. in circumference. The opened vessel showed a suggestion of dilatation, involving its base. There was no branch (nor any atrophic vestiges) from the pulmonary trunk to the left lung.

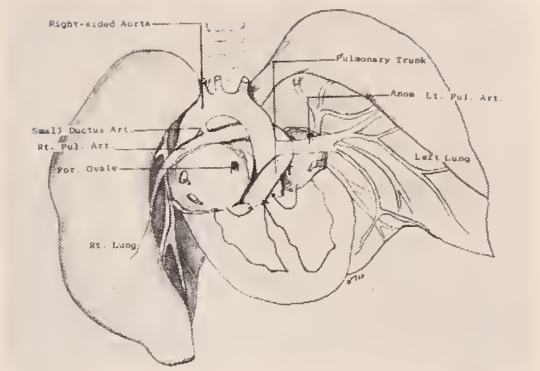


Figure 2—Diagram showing enlarged right atrium, foramen ovale, right ventricular hypertrophy, pulmonary artery with only a right pulmonic branch, small patent ductus arteriosus between right-sided aorta and right pulmonary artery, and the anomalous left pulmonary artery from the ascending aorta.



Figure 3—The anomalous left pulmonary artery, sutured carefully and opened along its entirety to show the vessel and its branches. (One dips posteriorly in the picture.)

The left atrium was of average size and shape and received the usual four pulmonary veins. The mitral ring measured 3.7 cm. in circumference, and its leaflets were unremarkable. The left ventricle was hypertrophied, measuring 0.7 cm. The aorta arose from its normal location, the aortic ring being 2.7 cm. in circumference.

The aortic valve presented the usual three cusps and two coronary ostia. Each coronary artery had the

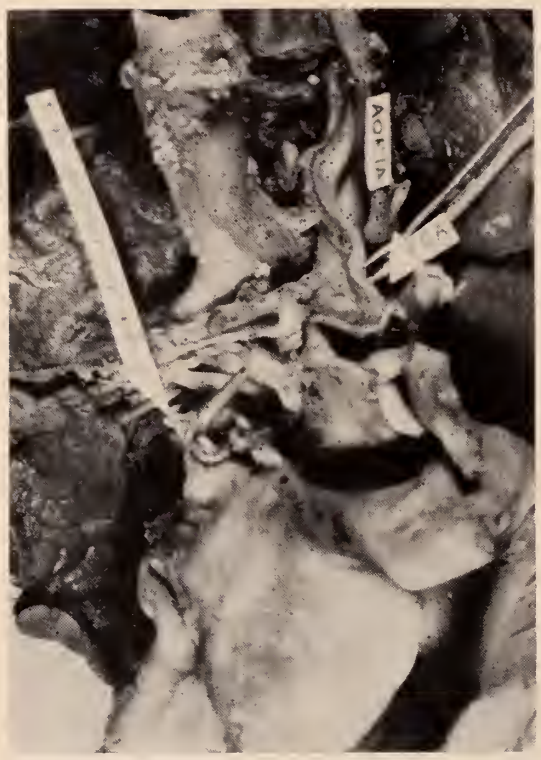


Figure 4—Aorta displaced to the left to give a better view of the probe-patent ductus arteriosus (P.D.A.) with its aortic and right pulmonary artery communications. (Note groove made by right-sided aorta at right tracheo-bronchial bifurcation.)

usual distribution. Near the base of the aorta, 1.5 cm. from the aortic ring, there arose the anomalous left pulmonary artery. (Figure 2) This was 1.5 cm. in circumference, originated from the left antero-lateral aspect of the aorta, curved about the anterior aspect of the pulmonary trunk just before the latter veered to the right.

Because of its location, the anomalous artery had to be partly cut in the dissection of the pulmonary artery. Its continuity was carefully reestablished with fine suture material prior to measurement and photography (Figure 3). As it left the neighborhood of the pulmonary trunk, the circumference increased from the original 1.5 cm. up to 1.8 cm., before it divided to enter the hilum of the left lung.

The arch of the aorta proceeded to the right and hooked over the junction of the trachea and the right main bronchus. It then continued posteriorly and caudad as the descending aorta. The superior aspect of the right tracheo-bronchial bifurcation showed a shallow but definite groove, 0.9 cm. in diameter, interpreted as due to aortic indentation (Figure 1). The arch of the aorta presented the usual three great vessels of a right-sided aorta; namely, the innominate, right common carotid, and right subclavian arteries.

The ductus arteriosus was patent, 2.3 cm. in length and 0.6 cm. in internal circumference. It connected the right side of the aorta just distal to the origin of the right subclavian artery with the pulmonary artery, 0.5 cm. before its right hilar division (Figures 2 and 4).

Sections of the heart showed myocardial hypertrophy and subendocardial fibrosis. The other organs showed congestion, reflecting the cardiac decompensation. This was most marked in the lungs, where edema and many "heart failure" cells were seen bilaterally. In addition, small areas of pulmonary hemorrhage were seen in the left lower lobe.

The embryology of the great vessels has been well described.[7, 11]

Many theories had been postulated in an effort to explain the unilateral absence of a pulmonary artery and its anomalous origin.[12, 16] The case presented seems compatible with Sikl's theory (quoted by Winship, *et al.*[17]) in which there is postulated an abnormal dorso-rotation of the left truncoconal ridge resulting in the origin of the left pulmonary artery from the aorta.

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Saint Mary's Hospital

Thirty out of 50 hard-core heroin victims seem to have been able to kick the habit on this ambulatory program.

A Hospital-Based Methadone Program*

Ambulatory Induction Phase

Man Wah Cheung, M.D. and Anthony C. Pugliese/Metuchen

Until recently the Neuropsychiatric Institute at Skillman was the sole treatment center accepting methadone maintenance patients in New Jersey. They had a waiting period of at least three months. Applicants were admitted as inpatients for a minimum of six weeks. At Skillman, patients were first taken off heroin through detoxification with methadone. This took from five to seven days. Then came a waiting period of ten days to determine if the patient qualified for methadone maintenance, the qualifications being that the patient was at least eighteen years of age, had a two-year established regular heroin habit, and had unsuccessfully tried other "drug free" methods of treatment.

Once the patient was accepted into the program, he was immediately given a meticulous physical examination and any medical problems were attended to. Daily dosage of methadone would begin at 10 mgm. and gradually be increased to between 90 mgm. and 120 mgm. by the end of three weeks. During this time, his day included repeated medical observations, daily activities, assigned chores, and group counseling. Once maintained on the methadone, every effort was made for rehabilitation of the patient.

At the end of the induction period, the patient was assigned to a maintenance clinic near his home. He would attend the clinic once a day to receive his methadone which was dissolved in orange juice. He would drink this in the presence of a nurse or physician Each day the patient would submit to a urine test which would detect whether he was shooting up heroin or other detectable drugs. The patient was assigned a social worker who would counsel him and attend to his social needs.

Roosevelt Hospital, in Middlesex County, served as one of several maintenance clinics in New Jersey. The program is funded by the State Department of Health, Bureau of Narcotics and Drug Abuse, and has been operating in this capacity since April, 1970.

The Ambulatory Induction Phase of the methadone program began at Roosevelt Hospital on July 26, 1971. We feel that intermediate and long-term results with ambulatory induction equal those obtainable with inpatient induction, although the initial attrition factor seems to be somewhat higher.

Before acceptance into the program, patients are initially screened at the Middlesex County Drug Treatment Center in North Brunswick. At the center the candidate is seen by an experienced ex-addict counselor and a trained social worker. An exhaustive social history is done on the patient. He is then scheduled for a screening before the methadone staff at the hospital. The screening committee consists of the director of the program, clinic physician, nurse, social worker, psychologist, and an ex-addict presently on methadone. To qualify for the program, the

patient must express an earnest desire to stop using abusive drugs. He must be at least eighteen years of age and a confirmed heroin addict of at least two years' duration. With respect to having tried other "drug free" methods of treatment, this requirement is waived if the staff feels that the patient desires to be on methadone far more than he desires any other type of treatment; especially if the addict has children and cannot afford to leave his family for inpatient treatment. Even an older patient, who is not married has very little chance of making it in a therapeutic community.

Once accepted the patient reports to the clinic each morning at 9 a.m. where he submits to a urinalysis and is given his daily dosage of methadone under professional medical observation. During the day he is provided with recreational and social activities as well as individual and group counseling. Every effort is made to prepare the individual for his acceptance back into society.

The hospital overlooks a park which gives the clinic a rustic atmosphere and provides the patients with tennis, fishing, baseball, picnicking, and miles of hiking trails. The hospital also borders the Menlo Park Shopping Center which offers social opportunities as well as easily accessible transportation to and from nearby communities for the patients. At our occupational therapy department patients are permitted twice a week to work in the woodworking shop, kitchen, or arts and crafts center.

The induction program is on a seven-day per week basis for three weeks. The patient attends the clinic from 9 a.m. to 4:15 p.m. each day. His day is scheduled for him with emphasis on social rehabilitation and specific recreation periods. This day is mainly spent in a large room in the hospital which contains a pool table, ping-pong table, library, lounging area, rest rooms with showers, and a modified kitchen area for snacks. These patients are permitted to eat with staff members in the cafeteria. They are the only patients allowed in the staff cafeteria.

The induction group may number anywhere from two to twelve in number. The ideal number is between six and eight at one time. When the program first started, two to three new patients were accepted each week; however, we found that for orientation purposes and group counseling, it was better to accept six to eight patients as a group and have them attend the induction phase for the three week period. One disadvantage of this was the possible long waiting period (three weeks) once a patient was accepted. This was solved by maintaining the patient on a low dosage of methadone (about 25 mg.) until he was ready to start the induction phase.

The following represents a recommended ambulatory induction schedule:

1st Day	10 mgm.	5 mgm.*
2nd Day	10 mgm.	10 mgm.*
3rd Day	15 mgm.	10 mgm.*
4th Day	20 mgm.	10 mgm.*
5th Day	35 mgm.	5 mgm.*

*At closing time of clinic

6th Day	40 mgm.	
7th Day	45 mgm.	
8th Day	50 mgm.	
9th Day	55 mgm.	
10th Day	60 mgm.	
11th Day	65 mgm.	
12th Day	70 mgm.	
13th Day	80 mgm. or	75 mgm. @ 8 a.m.
14th Day	80 mgm. or	80 mgm. @ 8 a.m.
15th Day	100 mgm. or	85 mgm. @ 8 a.m.
16th Day		90 mgm. @ 8 a.m.
17th Day		95 mgm. @ 8 a.m.
18th Day		100 mgm. @ 8 a.m.

Of the fifty patients built up on the ambulatory induction program since July 1971, thirty are working, attending school, or managing a household. Sixteen per cent of them are unemployed as compared to a twenty-five per cent rate for all patients on the program. Three individuals have voluntarily "detoxed" from the program, and of the three, one has returned to heroin, one remains drug free, and one has recently returned to the program.

Two patients have died from non-drug related causes. Five of the original fifty patients have been incarcerated; four from charges incurred prior to entering the program.

The staff needed to cover the ambulatory in-

duction phase of the program would include a program director, who also directs the maintenance and detoxification phase; one part-time physician; a full-time registered nurse; a part-time registered nurse; an ex-addict counselor; and a social worker.

The advantages of a hospital-based ambulatory induction program are its relative inexpensiveness (about $1,200 per patient as compared to $6,000 per patient in an inpatient program), short duration, and more spontaneous initiation of maintenance. Waiting times for admission to an induction center can present a serious problem and lead to losing patients who otherwise could be helped. In New Jersey, this is accentuated by the fact that only one inpatient facility is available for induction of patients for State Department programs. Because of its limited bed space, waiting times at the New Jersey Neuro-Psychiatric Institute, Drug Addiction Unit, have been constantly increasing. This is highly undesirable from a therapeutic standpoint.

Another advantage of ambulatory induction is that the patient returns to his environment each day and faces his problems. Upon return to the clinic in the morning he is provided with the professional help to deal with these problems.

With some patients returning to the old environment could be a disadvantage, especially before they reach a blockage dose (between 60 and 80 mgm.) of methadone. However, through sound counseling and supervision, these individuals can make it.

An important feature of a hospital-based methadone program is acceptance of the patients by other hospital employees. Frequent seminars are held for employees of the hospital to acquaint them with what we are trying to do. Although there are still individuals who oppose the program, most have accepted the clinic as a means of treating ill patients—their illness being heroin addiction.

Since family members of the patient play an important role in rehabilitation, group sessions are conducted once a week for them. All group sessions are on a voluntary basis.

The Drug Addiction Unit of the New Jersey Neuropsychiatric Institute will continue to receive and handle those patients with whom outpatient induction is anticipated to be difficult and who require inpatient care for induction.

Roosevelt Hospital

Sickle Cell Disease in Non-Blacks

Sickle cell disease, commonly thought to affect only blacks, is also found in other races in Southern Europe, the Middle East, and India, says a report in the April 30, 1973 issue of the *Journal of the American Medical Association*.

The disease is hereditary, causing, in severe cases, considerable pain, disability, and death. It is transmitted through the parents to their offspring through a defective gene. In the United States it has been found only in blacks.

The greatest concentration of the sickle cell gene occurs among the native populations of equatorial Africa. However, scattered groups carry the sickle cell trait in southern Italy and Sicily, certain areas in northern Greece, and in populations of central and southern India. It also has been noted among Yemenite and Iraqi Jews and in southern Turkey, southwestern Arabia, and within the oases of eastern Saudi Arabia.

Even in this antibiotic age, brain abscess is still with us, and, to a great extent, is a treatable disorder.

Brain Abscess

Richard E. Pelosi, M.D./Fair Lawn

Although decidedly less frequent now than it was in the pre-antibiotic era, brain abscess has to be seriously considered in the differential diagnosis of increased intracranial pressure and mass lesions. Too often brain abscess is not sufficiently considered with consequent tragic sequelae.

Chronic brain abscess is particularly deceptive in that it closely simulates the course of a malignant brain tumor, especially glioblastoma multiforme or metastatic tumor. The rapid development of single or multiple mass lesions with mass effect overshadowing infection can be quite misleading. An added danger is that laboratory and x-ray data (including contrast studies) frequently fail to reflect the true nature of the problem. The final point of confusion is in the realm of therapy in that many hospitals, including well-known medical centers, will treat such patients with "an obvious malignancy" without tissue verification.

The following cases illustrate the problems involved in the diagnosis, course and treatment of brain abscess.

Case One

A 72-year-old male was admitted to a hospital with a three-week history of headache, increased lethargy, vomiting, right-sided weakness, and a grand mal seizure. He had had an ear and mastoid operation in childhood and again 25 years ago with resultant severe hearing loss on the right side.

On admission his temperature was 101.6, blood pressure 140/70, and pulse 96. The patient was moderately dehydrated. There were coarse rhonchi but no rales on pulmonary examination. He was a lethargic, but easily arousable patient with a mild organic mental syndrome. There was papilledema and mild right central facial paresis. Deep tendon reflexes were increased on the right side with a positive Babinski and moderate right hemiparesis. Laboratory data were unremarkable. Lumbar puncture revealed an opening pressure of 280 millimeters of water. There were ten cells, four of which were polys and six were lymphocytes. The sugar was 70 and the protein 140. Smear and culture were negative. The EEG revealed a destructive lesion of the right frontotemporal region. A technetium brain scan showed a positive uptake in the mid-temporal region. A right carotid arteriogram demonstrated a very large holotemporal intra-axial mass lesion with shifting of the midline structures to the left. The study was reported as a probable glioblastoma, especially since abnormal malignant-appearing vessels were seen.

The patient was placed on large doses of steroids in the form of decadron and antibiotics consisting of ampicillin empirically. The initial consensus was to treat the patient with cobalt irradiation and long term steroid therapy. The patient, however, over a one-week period made a dramatic improvement with the steroids and antibiotics so that suspicions were aroused as to the etiology of the mass lesion. We elected to perform a craniotomy for a radical tumor removal and at surgery, to our surprise, found a well-encapsulated anterior and mid-temporal lobe brain abscess with surrounding edema. This abscess was accidentally opened during the dissection and was consequently drained; the capsule was then totally excised. The patient made a complete and gratifying recovery and was sent to an ENT surgeon for further evaluation and treatment. He is now two years post-operative and has no apparent deficits.

Case Two

A 61-year-old female, mildly diabetic and hypertensive, was admitted with a several week history of moderate headaches, mental changes, ataxia, left-sided weakness, and a grand mal seizure. On admission, she had a temperature of 100, blood pressure 160/100, and pulse 80. Physical examination was unremarkable except for moderate exogenous obesity. Neurologic evaluation revealed mild organic mental changes and confusion, early papilledema, mild left hemiparesis and ataxia especially on ambulation. Laboratory data including cerebro-spinal fluid studies were unremarkable. EEG and brain scan reported a mass lesion of the right fronto-temporal region. Right carotid angiogram revealed a large, relatively avascular mass of the frontal lobe with a rounded midline shift of the anterior cerebral vessels. Diagnosis, preoperatively, was astrocytoma of the right frontal lobe. Since it was the nondominant frontal lobe and relatively anterior in location, craniotomy and frontal lobectomy was decided upon instead of steroids and irradiation alone. At surgery a large well-encapsulated frontal lobe abscess was encountered and opened. The chronic abscess was drained and then totally excised. The patient was treated with antibiotics and made a full and uneventful recovery. Her diabetes and dental caries were also appropriately treated.

Case Three

A 39 year-old housewife had recent history of right focal seizures, dysphasia, and right hemiparesis. Examination revealed a mild dysphasia, no papilledema, but a mild central facial paresis and hemiparesis. EEG disclosed a probable destructive lesion of the left parietal region and a brain scan revealed a slight positive uptake of the same region. Cerebrospinal fluid studies were unremarkable. Left carotid arteriogram suggested an early infiltrating lesion of the dominant left parieto-temporal lobes. She was placed on anti-convulsant medication and observed for six weeks. Progression of symptoms, however, necessitated re-evaluation and admission. A brain scan and carotid arteriograms at this time revealed a definite infiltrating mass lesion of the left parieto-temporal lobe with moderate to marked shifting of the arterial and venous structures, indicating a deep extension of the tumor plus edema. Because of rapid development of the mass lesion, involvement of the dominant hemisphere and severe speech disturbance, the patient was treated with cobalt irradiation and steroids. After three weeks of this, she continued to deteriorate and developed a febrile course. Cerebrospinal fluid revealed 40 white cells with 90 per cent lymphocytes. She was started empirically on ampicillin and isoniazid therapy. Chest x-ray and urine and blood studies, as well as spinal fluid studies were negative. The patient was then transferred to our hospital for neurosurgical care in a virtually pre-moribund state. Left carotid arteriogram revealed no midline shift at this time; however, she had mild ventricular dilation and what appeared to be a deep parietal, relatively avascular, infiltrating mass lesion.

Ventriculogram was done to evaluate for a deep and partly obstructing lesion; however, none was found. A left parietal craniotomy was then performed for purposes of biopsy. Instead a well encapsulated, large, chronic, tuberculous brain abscess was encountered and totally excised. Overlying and adjacent cerebral cortex was later reported as indicating tuberculous meningitis. In spite of massive anti-tuberculous therapy and the removal of the large mass, the patient continued to deteriorate and expired ten days later.

Case Four

A 47 year-old male schoolteacher had a history of headaches, vertigo, and occasional vomiting, plus increasingly severe ataxia. Examination revealed papilledema, bilateral coarse nystagmus, mild right facial paresis, bilateral ataxia, especially truncal, with inability to stand and walk. Even sitting up caused falling backwards. EEG and a brain scan were unremarkable. Carotid and brachial arteriography revealed moderate ventricular dilation and anterior displacement of the basilar artery on the clivus. A pantopaque ventriculogram exhibited occlusion of the acqueduct of Sylvius and the fourth ventricle with a midline cerebellar mass lesion or tumor. A suboccipital craniectomy was done and a granulomatous abscess was removed from the cerebellum. The fourth ventricle was unblocked and cerebrospinal fluid flow was re-established. Postoperatively the patient did well for twelve hours and then had a sudden cardio-respiratory arrest. In spite of supportive measures the patient died three days later. Autopsy revealed multiple, chronic nocardia asteroides abscesses of the cerebrum and brain stem. The patient had not received any antibiotic nor antifungal medication.

Although, in the literature, hematogenous, metastatic abscesses from suppurative processes elsewhere in the body, especially the chest, are ranked as the most common in the etiology and pathogenesis of brain abscess, this has not been borne out in our limited experience. A second group has been more commonly found by us, specifically abscesses emanating from suppurative lesions of the nasal sinuses and otitic locations.

The third most common group in the etiology of brain abscess is that related to congenital heart disease. However, this special topic will not be discussed at this time.

Similarly, cerebral abscesses related to direct head injury with related intracranial contamination, although next in frequency and importance, are not represented herein.

The causative microorganisms most commonly found are staphylococcus aureus, followed closely by hemolytic streptococci, anaerobic streptococci and streptococcic viridans, pneumococcus, and the coliform organisms including proteus vulgaris. Tuberculosis and actinomyocosis are rarely found in this country. Fungal abscess such as nocardiosis are exceedingly rare. Nevertheless, they cannot be excluded from differential diagnosis. Intercontinental travel is easy and prevalent today. Our patient in the third case (above) lived for many years in Egypt and Australia, and the fourth patient had traveled extensively in Europe and Asia as a civilian with the foreign services. Parasitic diseases, especially amebiasis and ecchinoccocal hydatiform cyst and cysticerci are prominent causes of brain abscess although not usually in this country. In 20 to 25 per cent of the cases, sterile abscesses are found and no causative organism can be elicited.

In our small selected series, distribution of the location of the abscesses is equal in the four usual areas, however, most series show the highest incidence occurring in the frontal lobe followed by the temporal lobe, then the parietal and occipital lobes in that order. Next in frequency are the cerebellum and the brain stem.

Those abscesses related to nearby infective processes (such as bone, sinuses, mastoids and so on) are usually superficial in location and due to contiguous spread or, more likely, retrograde thrombophlebitis intracranially. Metastatic abscesses spread by the hematogenous route are, as a rule, subcortical, deep-seated, not infrequently paraventricular, and commonly in the distribution of the middle cerebral artery. Mastoid and otitic infections have an affinity for the temporal lobe and the cerebellar hemispheres. Frontal and nasal sinus purulent lesions cause subdural empyema and frontal lobe abscesses in the majority of cases. At least 50 per cent of the cases have multiple abscesses.

The diagnosis of brain abscess is not easy clinically without laboratory and x-ray data. The most important ingredient for the diagnosis is awareness that this entity still exists. The patient does not have to be an advanced diabetic, debilitated, or pre-moribund to harbor a brain abscess. Otherwise healthy individuals at any age can harbor a brain abscess, although it is slightly more common in the first three decades of life. In 20 per cent of cases no obvious cause of intracranial suppuration can be found.

Symptoms are usually non-specific such as headache and occasionally vomiting and lethargy; more specific symptoms are frequently local or generalized seizures.

Signs of brain abscess are related to the area of neural tissue involved such as hemiparesis with frontoparietal lobe involvement and ataxia, intention tremor and nystagmus with cerebellar involvement. Papilledema is present in over 50 per cent of the cases. Blood pressure and pulse will depend on the degree of increased intracranial pressure. Temperature is uniformly normal or subnormal unless there is concomitant infection elsewhere in the body or in the meninges.

Examination of laboratory data may not be helpful. Blood count is usually normal. Cerebrospinal fluid studies show increased pressure in almost all cases. A deep chronic abscess may reveal no cells, sugar, or protein change, whereas a superficial and poorly encapsulated mass will reveal an abnormal cell count, usually in the range of 10 to 200 cells with a moderately increased protein content and a relatively normal sugar content.

The EEG is helpful in that frequently there are delta slow waves with phase reversal indicating an underlying destructive process. Radioisotope brain scanning is very sensitive in picking up a "hot" abscess, indicating a break-down of the blood brain barrier in this location with edema, abnormal vascularity, and tissue destruction. An ECHO will reveal a shifting of the midline structures except in those cases involving the posterior fossa.

The most definitive contrast study is the cerebral arteriogram which portrays the mass lesion and the specific location of the lesion. Chronic well-encapsulated lesions are readily seen with a blush or stain outlining the abscess capsule. More frequently, however, the area involved reveals non-specific and relatively avascular mass effect.

Patients with increased intracranial pressure, poorly localized signs, and negative contrast studies require ventriculography to evaluate the posterior fossa structures, especially the cerebellum and brain stem, and to delineate obstructive lesions.

Treatment is both medical and surgical, the latter beginning with Macewen back in 1880. Massive doses of antibiotics are administered, depending on culture and sensitivity studies, with such agents as intravenous ampicillin, chloromycetin, methicillin, and/or intramuscular kanamycin or gentamicin. Intrathecal antibiotic administration is not considered necessary in these cases. Tuberculous or fungal infection obviously requires heroic measures with the appropriate antituberculous agents such as isoniazid, streptomycin and ethambutal. Fungal disease agents include sulfonamides and Amphotericin B. Surgery consists of total excision of the easily accessible and chronic, well-encapsulated abscess wherever possible, especially if the

lesion is obstructive to the normal circulation of cerebrospinal fluid. Those lesions which are very large, poorly encapsulated, not easily accessible, (such as in the basal ganglia or thalamus), or multiple should be aspirated through a burr hole or through a craniectomy site. A local antibiotic can be instilled into the abscess using agents such as bacitracin or polymixin B depending on the organism type. Microbarium sulfate is also injected into the abscess cavity to gauge the size and later growth or shrinkage of the mass with therapy. The abscess can be tapped and aspirated as often as is necessary during the course of the intensive antibiotic treatment until it disappears or until it can be readily removed by surgical means.

The prognosis is steadily improving from the pre-antibiotic era mortality of 75 to 90 per cent to a present mortality rate of 10 per cent to 30 per cent. This selected series is too small to be of statistical significance but instead readily outlines most of the problems involved in the diagnosis and treatment of brain abscess.

The sequelae of brain abscess depend to a great extent on the area of the brain involved: hemiparesis, dysphasia, ataxia, hemianopia, and so on. The only consistent serious residual in over 50 per cent of the cases was convulsive seizures. However, these are readily controlled with the usual anticonvulsant medications such as phenobarbital and dilantin.

Summary and Conclusions

Brain abscess remains an important and potentially highly curable form of intracranial mass lesion. Four selected cases were presented from a recent series that illustrate the difficulties in the recognition, diagnosis, and treatment of this disease entity. A successful course for the patient with brain abscess depends upon the physician's clinical astuteness in recognizing the problems and then implementing, along with his neurosurgical colleagues, the appropriate course of therapy.

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18 Bancroft Place

Folk Medicines Now Under Study

An attempt to find and classify medicinal plants used in folk medicine in parts of Texas and Mexico is being made by Dr. Clarissa T. Kimber, Texas A and M Foundation on a $4,675 grant from the HEW's Health Services and Mental Health Administration.

Believed to be among the first used in medicine on this continent, the plants are now becoming extinct. Dr. Kimber will make a survey of both cultivated and non-cultivated plants once used in the region for medicinal purposes, and will search for the sources of the wild varieties.

Herbal medicines thought to have real medical utility will be sent to researchers for chemical and pharmacological study. Some medicinal plants used in folk medicine centuries ago and then ignored have been found to yield drugs useful in modern medicine. An example is Rauwolfia, a plant whose roots produce reserpine, an important tranquilizer and hypotensive agent.

Must vasodilators and therapy for other diseases come into conflict?



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VASODILAN®
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the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1 Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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The hazard of drug therapy has become an important topic lately. We are here reminded that prescribing drugs to children presents several special features.

Unexpected Effects Related to Interactions of Drugs in Pediatric Use

Miles E. Drake, M.D. and Miles E. Drake, Jr., M.S./Vineland

The administration of more than one drug to a patient (especially during the pediatric age) must be the concern of the physician, not only because of the effect of the individual drug but also because of drug interaction. The prolonged administration of one drug may reduce the pharmacologic activity of another by stimulating its metabolic inactivation. Drugs may exert this effect by increasing the amount of drug-metabolizing enzymes in liver microsomes. This phenomenon is known as enzyme induction. The stimulation of liver microsomal enzymes may be pharmacologically important, for it may lead to an accelerated distransformation of the drug *in vivo,* resulting in diminished effect and lowered effective drug level in the tissue of the patient. Drug interaction may also occur in which the administration of one drug may inhibit the metabolism of a second drug, interfering with the breakdown, and giving rise to elevated drug levels in the patient's tissues, with adverse reactions.

Cucinell, *et al.*[1] showed that the prolonged and simultaneous administration of phenobarbital lowered the plasma levels of bishydroxycoumarin (Dicumarol®), resulting in a diminished anticoagulant activity of the drug as measured by prothrombin times. They showed that the administration of phenobarbitol in conjunction with diphenylhydantoin (Dilantin®) caused an acceleration of the metabolism of diphenylhydantoin. This led several investigators to study the effect of phenobarbitol on diphenylhydantoin levels in epileptic children. Buchanan, *et al.*[2] showed that mean blood levels of diphenylhydantoin after 28 days of phenobarbital administration were lower than the levels obtained prior to phenobarbital administration. Garrettson and Dayton[3] found that four of six patients receiving combined phenobarbital and diphenylhydantoin therapy had lower diphenylhydantoin serum levels, this confirming the findings of Buchanan.[2] These observations were also similar to those of Cucinell.[1]

Thus, phenobarbital, although not completely predictable, does enhance the metabolism and degradation of diphenylhydantoin. It is the experience of physicians treating convulsive disorders that an occasional child who is not completely controlled on one anticonvulsant drug will show an increase in the number of seizures on the administration of additional anticonvulsant drugs. This could be due to altered metabolism, because of induction of drug-metabolizing enzymes.

Prolonged administration of such drugs as phenobarbital or diphenylhydantoin may stimulate not only the metabolism of other drugs but also, in some instances, may stimulate its own metabolism. This was shown by Burns[4] in dogs. The induction of metabolism of a drug by its own prior use may give rise to

a diminished drug effect, which in itself may be an unexpected, and at times, adverse reaction.

The second type of drug interaction, inhibition of drug metabolism, may result in an untoward or unexpected prolonged or toxic drug effect on the patient. It is not rare to see a child on diphenylhydantoin or primidone (Mysoline®), who becomes hyperactive and in consequence is given methylphenidate (Ritalin®). This child can develop all the signs of diphenylhydantoin or primidone intoxication, namely ataxia and/or drowsiness.

Since primidone degradates to phenobarbital, Garrettson, *et al.*[3] have shown that methylphenidate (Ritalin®) caused a marked increase in phenobarbital, diphenylhydantoin, and primidone levels in the serum, and these anticonvulsant blood levels did not return to control values until six weeks after methylphenidate was discontinued. It should be pointed out here that proadifen hydrochloride (SKF-525), an experimental agent used in drug inhibition studies, and methylphenidate not only have similar chemical structures but have also similar *in vitro* effects on drug metabolism inhibition in homogenate of human liver. One of us has recently seen a child, given 50 milligrams of impromine (Tofranil®) every twelve hours, who was given 20 milligrams of methylphenidate (Ritalin®) every twelve hours to control her hyperactivity, develop mild drowsiness and ataxia 72 hours after Ritalin® was started. The discontinuation of both drugs resulted in return to a normal state and Tofranil® was again started two weeks later with no untoward effect. This, we believe, to be due to the impairment of Tofranil® metabolism by Ritalin.®

Although it has not yet been seen in pediatric patients, the drug interaction of isoniozid (INH) and diphenylhydantoin as noted by Brennan, *et al.*[5] is to be expected. This interaction is due to a genetic defect which leads to sustained high levels of free drug (INH) resulting in inhibition of diphenylhydantoin metabolism in direct proportion to the INH concentration in the serum. Slow inactivation of isoniozid also may predispose to diphenylhydantoin intoxication in persons receiving both drugs simultaneously.[6]

A genetic defect in parahydroxylation of diphenylhydantoin, giving rise to a continuous accumulation of unmetabolized diphenylhydantoin in the blood, has been reported by Kutt, *et al.*[7]

Physicians should identify those children receiving INH who are slow inactivators of INH prior to the administration of anticonvulsant drug therapy.

The knowledge that we now have of specific examples of diminished drug effect, due either to accelerated biotransformation of drugs *in vivo* or to elevated levels of a second drug resulting from interference with the breakdown of the second drug, should alert all of us to the possibilities of other adverse reactions. It is to be anticipated that other types of adverse drug reactions will occur in pediatric pharmacology, primarily producing neurologic symptoms or affecting the nervous system.

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947 North Main Road

While we have not yet achieved full speech rehabilitation after laryngectomy, we have made some good progress in that direction.

Carcinoma of the Larynx and Vocal Rehabilitation*

Alvin Glasgold, M.D. and Joseph Zullo, M.D./New Brunswick

Vocal rehabilitation following laryngectomy has always presented a problem. Impetus for this discussion comes from a brief article in a previous issue[1] of this *Journal* partially quoting a paper implying that a satisfactory surgical solution to post-laryngectomy vocal rehabilitation has been obtained.[2] This implication is misleading.

Laryngectomy connotes removing the larynx, exteriorizing the superior tracheal stump as a direct respiratory channel to the outside and closing the cervical esophagus. It eliminates the connection between the lungs and the mouth, and thus prevents the lungs from acting as a source of air for vocalization. This has led to a variety of substitute speech mechanisms. Buccal speech is the use of air retained in the buccal area to produce a breathy voice. Esophageal speech is the most common form of substitute speech. Air swallowed into the esophagus is regurgitated through the reconstructed cricopharyngeus which serves as a pseudoglottis, producing sound. This sound (vocalization) is then modified in the oral cavity into speech (phonation). Esophageal speech has generally been found to be a satisfactory mechanism of speech production. The ability to develop it frequently is proportional to the individual's needs and desires for rehabilitation to independent productive function. Thus the aged who do not have to return to work often are less motivated and less likely to develop esophageal speech. Effective esophageal speech requires some training and development, often takes many months. Once mastered, it can be an excellent means of communication. In many instances the listener is not aware that the speaker has undergone a laryngectomy. Drawbacks to esophageal speech include a narrow pitch range, the need for frequent pauses to ingest air, and the time and practice involved in mastering this new technic.

To preserve the voice, both radiotherapy and partial laryngectomy have been employed. These are useful in early small laryngeal lesions (Stage 1). In Stage 2 lesions which are not limited to a single site in the larynx, the application of radiotherapy or partial laryngectomy involves a significant statistical decrease in cure rate. Total laryngectomy provides the greatest chance of cure in all but the most limited laryngeal carcinomas. If reconstruction could include production of a channel for vocalization without its other drawbacks such as aspiration, this operation (laryngectomy) would be ideal.

The idea of producing a more normal speech mechanism in a laryngectomized patient goes back to 1927 when Beck[7] told of a patient who punched a hole in the posterior wall of his trachea to produce a tracheo-esophageal fistula. In 1958, Conley[3] reported on attempts to devise an intrinsic tunnel connecting the trachea and esophagus. This apparently failed because of aspiration of food through the tunnel. In 1967 one of us[4] cited the accidental occurrence of a tracheo-

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esophageal fistula in a patient which resulted in his ability to occlude his tracheal orifice similar to a tracheotomized patient and allow the expired air to pass through the fistula into the esophagus. It then proceeded through the narrow cricopharyngeus which served as a pseudoglottis for sound production and into the mouth for speech production. This patient had an excellent normal sounding voice. Aspiration was no problem because of the peculiar position of the fistula and its occlusion by an in-dwelling laryngectomy tube. Our attempts to reproduce this situation so that it could be routinely applied in laryngectomized patients failed. Since that time there have been a number of surgical procedures to fashion a tracheo-esophageal fistula or tube allowing the utilization of expired air for vocalization without the problem of aspiration. The operation which has been most used and which is most well-known is the Asai[5] procedure. In this, two openings are made into the trachea. The superior one is connected at a subsequent procedure by a dermal tube to an upper pharyngeal fistula for voice production. Although voice quality has been good, disadvantages to this procedure have been the necessity for two or three stage operations, stenosis of the tube and aspiration of saliva. Montgomery[6] devised a method of creating a pharyngostome at laryngectomy with secondary creation of a tracheo-esophageal fistula only if the patients did not develop adequate esophageal speech. Voice production has been good, but the fact that this is not an ideal operation is evidenced by its use only in those patients who do not develop esophageal speech. The advantage of the McGrail-Oldfield operation over the preceding two lies only in the fact that it has been developed as a one stage procedure. Again voice production is usually good, but they have encountered the same problems as previous operators in that aspiration of both food and saliva has been a significant hurdle. In addition, stenosis has also occurred. This procedure also needs a very adequate tracheal length, and it is questionable whether it could be used if subglottic extension were present. These patients are hospitalized from four to five weeks after surgery as opposed to our average laryngectomy patient who leaves the hospital on the eighth day after surgery. It may be that producing this one-stage operation as opposed to Montgomery's two-stage operation is actually a disadvantage in that possibly this procedure should only be reserved for patients who do not develop adequate esophageal speech.

Conclusion

Rehabilitative surgical procedures recently reported for developing speech after laryngectomy seem to be important steps toward an eventual ideal operation. This has not been reached as yet, however, and until that time the standard laryngectomy with subsequent esophageal speech production remains the most basic and widely used method of treatment and rehabilitation for extensive carcinoma of the larynx.

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330 Livingston Avenue

The scope of cardiac resuscitation technics in a community hospital is here graphically profiled.

Cardiac Resuscitation

A Six Month Review

Ralph G. Oriscello, M.D.*/Elizabeth

In May, 1972, Lemire and Johnson[1] determined that in a decade 1,204 patients suffering "cardiac arrest" were resuscitated in their general hospital by a mobile team. An over-all survival rate to discharge was 19 per cent. Some 75 per cent of the survivors were alive at the end of one year, 59 per cent at two years, and 51 per cent at three years. In the largest diagnostic group, coronary artery disease, the survival rates were similar.

This report prompted an editorial[2] that concluded that intensive training can increase survivors and that "maintenance of a system for optional delivery of cardiopulmonary resuscitation (CPR) is a continuing challenge to the staff and the hospital." Undoubtedly, they conclude, a quality program for resuscitation is worthwhile. This 19 per cent survival rate is one of the highest recorded. Upon initiating a survey at the Saint Elizabeth Hospital (a 340-bed, general medical institution) it was hoped that a survival rate in this range would be encountered. We were within range of 19 per cent. It is conceivable that modifications could lead to significant improvement.

Of the 50 documented cardiac arrests, there were 25 different admitting diagnoses, ranging from acute myocardial infarction to renal colic. The five most common were:

1. Acute myocardial infarction	24%
2. Pulmonary edema	20%
3. Arteriosclerotic heart disease	12%
4. Diabetes mellitus	10%
5. Cerebrovascular accident	8%

Of the 50 patients in this study, 30 were males. The age range of the 50 patients was 26 to 85. Average age was 63 years.

Duration of stay before the arrest occurred averaged 5.3 days. Longest stay prior to arrest was 168 days in a patient with metastatic breast carcinoma. This was not averaged with the other cases. Of the eight who survived to be discharged, the duration of stay after the arrest averaged 23.5 days. The total who survived to leave the hospital is 16 per cent of those suffering a cardiopulmonary arrest. The incidence of arrest in different locations is as follows:

1. Emergency room	2
2. Operating room	2
3. Coronary care unit	3
4. Surgical ICU	9
5. Patients' room	16
6. Medical ICU	18

As expected, the frequency of cardiac arrest was low in the Coronary Care Unit. Reason for this is the early recognition of potentially lethal rhythm disturbances, including irritable foci and conduction disturbances. Therapy has reduced the immediate mortality of acute myocardial infarction. This demonstrates the usefulness of early intensive coronary care. Of the three patients who died in the Coronary Care Unit, two demonstrated electrical-mechanical dissociation and one ruptured his left ventricle.

The CPR exercise was initiated by the following groups according to frequency of attendance when arrest occurred:

*Dr. Oriscello is Director, Department of Medicine, Saint Elizabeth Hospital, Elizabeth.

1. Attending staff	6
2. Nursing Staff	11
3. House staff	33

As pointed out by Killip, most unsuccessful results are in those who do not have good airway establishment. The number intubated was 30 out of 50. Of the eight survivors four were intubated and four were not. Rapid application of direct current shock is a factor in survival and the elimination of the necessity for intubation when ventricular fibrillation is present. The longer the exercise continues, the greater the need for the best possible airways, i.e., an endotracheal tube.

The following maneuvers were performed at the arrest exercise:

1. Direct current shock	9
2. Pacemaker insertion	7
3. Thump to the chest	9
4. Multiple shocks	7
5. Cutdown	9
6. Subclavian catheterization	3

"Thumping" alone has been documented to convert a ventricular tachycardia to normal sinus rhythm (NSR) and to generate an electrical focus in asystole. It should be emphasized as the first maneuver at any cardiac arrest. Subclavian vein catheterization should, generally, not be tried during closed chest massage because of the necessity of discontinuing the pumping maneuver for more than the recommended five seconds between depressions. Cutdown should be in a leg vein or an arm vein when available. Several poor outcomes were the result of sustained efforts at establishing an intravenous route via the subclavian vein.

The medications administered most frequently were:

1. Sodium bicarbonate	43
2. Levophed (Aramine)	28
3. Adrenalin	25
4. Isuprel	23
5. Calcium gluconate	17
6. Lidocaine	16
7. Atropine	10

Adrenalin was administered less frequently than expected. This is explained in part by early, effective defibrillation. It remains the drug of choice for both ventricular fibrillation and asystole, to coarsen the fibrillatory waves and make conversion by shock more likely or to generate an effective focus in an electrically inert heart.

Since digitalis sensitivity increases with age, severity of heart disease, azotemia, electrolyte abnormalities, pulmonary emboli, or recent myocardial infarction, the incidence of administration pre-arrest is of interest. Seventeen of the 50 were taking digitalis prior to their arrest. There was no record of digitalis therapy in ten. Twenty-three were not taking digitalis.

The incidence of prior cardiovascular disease was determined to be:

1. Arteriosclerotic heart disease	14
2. Hypertensive cardiovascular disease	8
3. Rheumatic heart disease	2
4. Pulmonary embolic disease	1

Post-arrest complications were frequent in the survivors generally being confined to transient hypotension or rhythm disturbances.

1. Serious rhythm disturbances	6
2. Congestive heart failure	6
3. Shock	4
4. Fractured ribs or sternum	2
5. Pulmonary or peripheral embolization	none

Cerebral edema therapy was needed in only one patient who survived less than 24 hours. The remainder were rapidly resuscitated to wakefulness. At that point mannitol, steroids, hyperventilation, and diuretics may no longer be needed and may even be dangerous because of induction of metabolic alkalosis with associated rhythm disturbances, which in turn are generally responsive to potassium chloride therapy.

The survival rate for those leaving the hospital in a neurologic condition similar to that existing before the arrest was 8 of 50 or 16 per cent.

1. Survived to leave hospital	8
2. Survived 24 hours or more	10
3. Survived 1 to 24 hours	2

Seven-eighths of the patients leaving the hospital were found to be in ventricular fibrillation at the time of the arrest, having been successfully cardioverted to a more physiologic rhythm. The eighth patient was primarily a respiratory arrest who was rapidly resuscitated from a marked bradycardia. Those found in asystole or with an electrical event without a demonstrable mechanical contraction by ausculation or palpatation all died. Although the numbers are small, it is obvious that the initial findings of these two conditions may be associated with a 100 per cent mortality.

The most common suspected causes of the cardiac arrest were:

1. Acute myocardial infarction	25
2. Pulmonary embolism	8
3. Pneumonia and hypoxia	6
4. Congestive heart failure	4
5. Recurrent, intractable arrhythmia	2
6. Pump failure	1
7. Rupture of myocardium	1
8. Ruptured aortic aneurysm	1
9. Quinidine synscope	1
10. Shock lung	1

Myths about cardiac arrest (occurring predominantly when few are around to lend assistance) are laid to rest. The time of the day of the onset of the arrest was noted to be as follows:

12 am– 2:59 am	5
3 am– 5:59 am	4
6 am– 8:59 am	6
9 am–11:59 am	6
12 noon– 2:59 pm	8
3 pm– 5:59 pm	7
6 pm– 8:59 pm	9
9 pm–11:59 pm	5

Between 9 AM and 12 midnight, 70 per cent of the arrests occurred. There is a fairly even distribution throughout the day, however, suggesting need for diligence on all three shifts.

Attendance at the earliest exercises of this series became a problem due to the response of excessive personnel. We are continually gratified by the interest and help of all the personnel devoted to patient care in our hospital. However, excessive numbers led to repeated delays and reduction of efficiency in administering assistance and responding to commands. This is a key reason for recommending formation of a team of CPR specialists.

The patient with the best chance for survival is one who has had an acute myocardial infarction, who manifests electrical instability and develops ventricular fibrillation. There generally is enough undamaged muscle to sustain life if cardioversion is rapidly achieved. This is supported by CCU morbidity and mortality figures. Modes of therapy must be developed to avoid lethal arrest in those with electrical-mechanical dissociation ("Pump-failure"). Iatrogenic causes can be reduced with continuing education programs during the active career of practicing physicians.

Thanks are extended to Doctors E. E. Federici, Giovanni Benincasa, Burton Bergman, and Marvin A. Berkowitz who helped in the collection of these data.

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1. Lemire, J. G., Johnson, A. L.: *New Eng. J. Med.*, 286:970 (May 4, 1972)

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225 Williamson Street

PATRONIZE OUR ADVERTISERS

The old crock need not be abandoned. Something can be done and here is a suggested blueprint.

The Rehabilitation of the Aged Disabled

Leonard D. Policoff, M.D./Princeton*

We sometimes conceptualize aging as an inexorable process of erosion, an expenditure of fixed reserves with closure of the account when the reserves have been totally depleted. This does not fit the facts at all. The human animal includes complexly interdependent biologic systems whose capabilities vary independently on an irregular and unpredictable chronologic basis. This, in turn, may modify the functional efficiency of some or all of the other systems. Major impairment in systems vital for biologic survival produce the catastrophic illnesses with which we are often faced in the rehabilitation of the aged. Equally significant impairments in the non-vital system can produce displacements in psychosocial adaptability without threatening life. These we are often less well prepared to manage in the rehabilitation milieu. This is particularly unfortunate since we can probably effect worthwhile improvements in these areas by modest environmental manipulation. We are often far less successful in the restoration of organic deficits.

In the rehabilitation of the aged disabled, it is essential that one distinguish between loss or impairment of regional or segmental body function and functional impairment of the total organism in its environmental-ecological relationships. The rehabilitation program which focuses on the segmental without regard to the needs of the total organism fails even when it succeeds.

Aging of the vascular and enzyme systems results in a lowered rate of tissue anabolism with slowing of replacement and repair but accentuation of disuse weakness and atrophy. Skeletal muscle loses contractile elements and there is a decrease in the elasticity of connective tissue structures. The result is a loss of muscle force, endurance, and skill. Coupled with this are the inevitable degenerative changes in the central nervous system with slowed reflex response and narrowed sensorial perception capability. Intellectual capacity, we are told, begins to deteriorate after the twenty-fifth year of life but compensatory experiential resources mask the changes. When major illness and disability occur, the anxieties and stresses produced may require the simultaneous satisfaction of many more intellectual energy demands than usual and an individual who might otherwise have functioned well for many more years is suddenly incapable of coping with the environmental stresses and demands. In his retreat to a posture of limited competence he may appear to have lapsed into intellectual senility. With proper management, such individuals are restorable. With poor management, the problem may become fixed. Certain principles are of universal validity in the rehabilitation of the aged disabled no matter which system failure has impaired segmental or total organism function. These principles have been reiterated frequently but they should be reviewed often:

1. Morbidity and mortality in the aged disabled relate more frequently to secondary disorders resulting from negligence and iatrogenic oversight than they relate to the original etiology of the disability.

(a) Thus, failure to avoid prolonged local pressures over bony prominences and to observe meticulous skin

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cleanliness and care will result in a decubitus ulcer. These can come on rapidly in 48 hours at times but seem to take an eternity to respond to appropriate local therapy. It is a sophistry to blame decubiti on poor nutrition or local vascular problems. Decubiti result from local external pressures for periods longer than 90 minutes to 2 hours. To avoid them, local pressure must be relieved by position change within that period of time on a regular, scheduled, physician-ordered, and supervised basis. Processed sheepskin pads, gelfoam pads, alternating pressure mattresses, circoelectric and water beds each have their adherents as prophylactic devices. Each is useful based on the specific anatomic area in question and the variables of skillful nursing service available but in the final analysis all of these methods will fail without intelligent physician-supervision of avoidance of prolonged local pressures.

(h) Individuals in the geriatric age group subjected to unnecessary bed rest are prone to develop pulmonary congestion leading to basilar stasis pneumonia. Where cardio-renal function is marginal (as it often is in these individuals) cardiac insufficiency and failure and renal insufficiency with sub-clinical uremia often occur as well. Bed rest and inactivity should be minimized in these people and the therapeutic goal is to have them out of bed, up and involved at whatever level of function is feasible the major portion of the 24-hour period. When prolonged bed rest is not avoidable because of intercurrent illness, pulmonary physical therapy in the form of chest tapotement, therapeutic exercise to increase chest cage expansion (except where severe emphysema exists) and to enhance diaphragmatic movement, and postural drainage should be added as routines in bedside care. To be effective these must be done several times in each 24-hour period as long as the unphysiologic enforced bed rest continues.

(c) Bedrest produces more rapid disuse weakness and atrophy of musculature in the aged and the process is not so rapidly or completely reversible. Osteoporosis with impaired calcium metabolism is almost a physiologic status in the well-aged but in those subjected to prolonged bedrest (as a result of disease or disability) the process is significantly accelerated with increased danger of pathologic fracture and of hypercalciuria with renal calculi providing an additional stress to impair further the marginal renal function. The remedy is to apply sufficient axial stress to bones to encourage osteoblastic activity and to minimize osteoporosis. Standing, walking and even assisted active exercises in the recumbent position will provide some desirable axial stresses.

(d) Categorically, to condemn catheterization in the aged disabled would be a mistake, since there are some central nervous system disorders in which the catheter is unavoidable. Having acknowledged the inevitable, I should like to condemn the frequency with which catheterization is applied to the aged disabled. Too often the catheter does not subserve the physiological needs of the patient but the convenience of the ward nurse who resents having to change the wet linen at frequent intervals in order to avoid bad odors and the necessity for repetitious skin care. The use of an indwelling catheter insures the development of a small contractured bladder of inadequate capacity which will perpetuate the incontinence it seeks to correct. Its ill effects can be minimized by irrigation at least twice daily and by clamping the catheter between bladder emptying to patient's tolerance up to four hours at a time, whenever the residual urine level after voiding is less than 20% of a total bladder capacity. Intermittent catheterization is a more tolerable method but it must be carried out under surgical asepsis to delay the onset of the ascending urinary tract infection which afflicts patients in both this method and the use of the retention catheter. When genito-urinary tract infection does occur, the type of antibiotic used is much less significant than insuring a high liquid intake and maintaining urinary pH in the acid range by the use of the classic urinary acidifier medications. Many aged individuals who appear incontinent while inactive or at bed rest overcome this problem when erect posture with increased abdominal muscle tone is allowed to assist. The catheter should be removed in such individuals as soon as bladder empyting is adequate for renal function despite occasional lapses in their sphincter control.

2. The aged, in general, do not have the strength and endurance of younger individuals hence their activities program should permit shorter treatment sessions within their fatigue tolerance, with sufficient repetition of therapeutic activity to achieve desired goals. The elderly may have slowed reaction times and lessened attention span. Again the process of relearning lost skills may require shorter periods of practice, at a slower pace with more frequent repetition to achieve lesser results than can be accomplished for the same level of disability in a younger individual. In the aged, one should be less concerned with cosmesis and more with function. Thus, it is nonsense to insist that every above-knee amputee learn to walk on their prosthesis without a trace of a limp. It is more important that their gait pattern be safe and stable. Realistic achievable goals are essential for proper management of these individuals. If goals are set higher than they are physically capable of reaching, they may withdraw into non-communicative depression. The aged are already too often displaced in the psychosocial sphere with narrowing horizons and diminishing interpersonal relationships. If discouraged in their pursuit of physical restoration, they may withdraw from all life participation while they await the final solution to their problems. It is of importance that their goals be set as small achievable increments which will produce enough success to encourage an approach to the next incremental goal. The wise physician will also have handy some alternate goals so that if the current objective appears on experience to be unattainable one can deftly substitute a less arduous one. Limited goals in self care even when they require a semi-sheltered or structured environment for achievement are very worthwhile. If they allow the individual to retain personal dignity and self-respect at home and to avoid the personal dissolution inherent in a nursing home situation they are both economically and socially worth our best efforts. Whatever the physical goals, they can never be separated from socialization, family participation and community relationships. Outreach programs which encourage the patient to consider the rehabilitation center or the extended care facility as transient stops on the way to the broader life style of the outside world are an integral part of restorative services and may involve institutional psycho-social and recreational therapeutic personnel working in close harmony with family, friends, and community resources. It does little good to restore the function of an extremity if one cannot restore the total organism to its environmental relationships and communications. The step from the front door of the institution to the front door of the home may be geographically miniscule but psychologically a horrendous barrier. The physician can delegate some of the leg work in this transition to his psycho-social associates but if he does not get personally involved he may have failed the patient in his most vital restorative needs.

This paper has not attempted to discuss the

specifics of management of the common disabling disorders of the aged: the vascular lesions of cerebral, cardiac, and peripheral localization: the arthropathies: the neuromuscular disorders and the traumatic involvements of the musculo-skeletal system. Arthritis in the elderly for example is managed much the same as in the young within the framework of the limitations we have reviewed and the understanding that drug tolerances are less and drug idiosyncracies greater in the aged. The methods of management are therefore well known and only require understanding modifications to fit the physiologic restrictions imposed by the aging process. It is important not to be deterred from our rehabilitation goals by the apparent frailty of the aged. They have been tough enough and survived long enough to reach this problem age. They often have greater resources both physically and emotionally than superficial observation would suggest and we must never deny them a trial at the restorative process, despite appearances which may be surprisingly deceptive!

253 Witherspoon Street

New Suicide Pamphlet

"Suicide is a very democratic phenomenon. It knows no discrimination of race, color, creed, age, or sex. Nor is it true that a person has to be mentally deranged to commit suicide. Depression is the disturbance most commonly found as a backdrop to suicidal behavior, especially in persons over 40."

Those are some of the observations made in *Dealing with the Crisis of Suicide,* a new Public Affairs pamphlet by Calvin J. Frederick and Louise Lague. The authors explore the taboos, tragedies, and statistics of suicide. They discuss who commits suicide, why, and how you can help prevent it. They tell where to turn for help and offer some basic psychological first-aid in a suicidal crisis.

Contrary to some widely held assumptions, "national figures indicate . . . an increasing trend toward suicide among blacks and other minority groups. In some big cities . . . the suicide rate among black males up to the age of 35 is much greater than among white males of the same age. . . . Entrenched feelings of helplessness appear to afflict blacks more than whites. . . . Compounding the problem, black communities have not had adequate psychological and medical services."

Among American Indians, the suicide rate in some tribes is at least five times higher than the national average, and most Indian suicides occur among the young. As Frederick and Lague point out, "As tragic and final as suicides is, (for the Indian) it is but a symptom of a deeper underlying problem—living in a hostile environment."

The role of the volunteer in preventing suicide cannot be over-emphasized, say the authors. Many of the hundreds of suicide prevention centers are now using the elderly, the retired, the disadvantaged, and the teenager, who want to do something "useful" "and we have learned that no amount of technology, education, and funding can substitute for a willing, patient ear, and sympathy on the part of every human being for every other."

Dealing with the Crisis of Suicide is No. 406A in the Public Affairs Pamphlet series, now in its 37th year. The series includes many other titles covering health and science, family relations, social and economic problems, race relations. All pamphlets sell for 35 cents each and may be purchased from the Public Affairs Committee, 381 Park Avenue South, New York 10016.

Here described is the open door to a new paramedical profession.

Special Article

Planning for Career Ambulance Profession

John C. Harvey, M.D., Washington, D.C.*

A Career Ambulance Profession may sound like a peculiar title in today's world. It will not be in tomorrow's world. In the United States, the three major causes of death are heart disease, cancer, and trauma. Trauma is primarily the result of automobile accidents. The increased number of automobiles in the United States, the improvement in the national highway system in the past decade, the increasing mobility of American citizens in their life styles all indicate that unless significant changes are made in the safety features of automobiles, and appreciable improvements are made in the driving habits of American citizens, death from trauma due to automobile accidents will soar in the next several decades in the United States. Much is being done to improve automobile safety. Drivers are being educated. Our national highways and local streets are being improved. Alternate methods of transportation to the automobile are being developed. Yet the prediction is that death from trauma encountered in automobile accidents will continue to increase and finally become the number one killer in the United States.

Many of these deaths are preventable. Too often they were the result of incorrect handling of traumatized victims at the scene of the accident or during transportation to the locale for definitive therapy. It has been estimated that over 40 per cent of the deaths as the result of automobile accidents might have been prevented through proper handling.

A wide variety of agencies handle the victims of accidents at the scene, and transport victims to the hospital. Many of the individuals in these activities do a good job, but the vast majority are not as well trained as they should be. They are well intentioned, well motivated, but because of incomplete understanding create more havoc than necessary.

The Federal Government through its Department of Transportation has been active in trying to correct this situation. Even before the Department of Transportation was created, farsighted and visionary physicians such as Oscar P. Hampton, Jr., M.D., of St. Louis and "Deke" Farrington, M.D., of Minocqua, Wisconsin, have for years, pointed out this sad situation. Professional organizations such as the American College of Surgeons, the American Academy of Orthopaedic Surgeons, the American National Red Cross, and the American Heart Association have all been preaching and actively working for improvement in the services rendered to the victims of accidents at the scene and during transportation to the hospital.

Today—with expanded health services demanded by consumers, with the pattern of distribution of physicians and nurses, with the increased utilization of a more sophisticated variety of health care services—a large group of allied health professionals is emerging. They are equipped to perform certain task-oriented duties in relation to health care and/or to handle, under the direction of physicians and nurses, certain delegated technical services and duties.

Much credit for the development of the allied health professional concept must go to the armed forces. The concept began in World War I and II and continued through the Korean War and the Viet Nam conflict, culminating in the highly skilled "paramedic personnel" of today. One of the allied health professionals developed by the armed forces was the "paramedic in the field," who correctly administered first aid and lifesaving medical procedures. Utilizing the most so-

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phisticated medical evacuation system ever developed, these personnel have reduced the mortality rate from trauma on the battlefield to hitherto unknown percentages of below one per cent. The civilian population has learned much from the experience of the Viet Nam conflict and the lessons are beginning to be applied in our national life. There is need, now, for a "paramedical individual" to bridge that gap between the emergency patient and the doctor. There is need to have advanced and in-depth training which permits the "paramedic" to treat the acutely ill and injured, under supervision of the physician, so as to preserve life and prevent disability from accident.

Thus, a new professional career is being developed, that of the Career Ambulance Profession.

Some may argue that this is not new at all, and that there are many areas in the world where there are career ambulance professionals. Members of the countries of the British Commonwealth of Nations will point with pride to the various organizations known as the St. John's Ambulance Brigades, and the brilliant work that these trained individuals have done. Such volunteer efforts are excellent and will continue, but the trained career ambulance professional is more than a volunteer. He is more than a first aid trainee. He is a truly professional individual, working under the supervision of physicians, rendering an integral part of medical care as it relates to the immediate effects of trauma. As this profession develops, no longer will the victims of accidents be treated by well-intentioned but poorly-trained individuals.

Most individuals today, who have activities of this nature—firemen, policemen, volunteers, employees of mortuaries or hospitals, have in the past had to be graduates of high school and receive varying amounts of first aid training generally rendered by Red Cross instructors. The American Heart Association has been outstanding in promoting training programs in cardiopulmonary resuscitation, an activity vitally needed at the scene of most accidents. Under the aegis of the National Academy of Science—National Research Council, the United States Public Health Service, and the United States Department of Transportation these various programs were melded together into a sophisticated training curriculum developed by Dunlap and Associates under contract to the United States Department of Transportation. This program prescribed a course curriculum for the improved level of training for personnel beyond the level of skills provided by the advanced first aid course of the American Red Cross. It is known as the Dunlap Curriculum for Emergency Medical Technicians.†

This course includes classroom and practical experience requiring instruction by physicians and other members of hospital staffs, both for initial training and for refresher follow-up training. It has become the standard at the present time for the training of ambulance drivers, attendants, rescue personnel, and others who provide emergency medical care at the scene and enroute to the hospital, or other emergency facilities. It is too early to evaluate the effect of this training upon the outcome of trauma. This broad-based training for on-the-spot first aid and for medical care enroute to a hospital or other emergency facility permits the successful student to take the examination for the National Registry of Emergency Medical Technicians. Anyone who completes the Dunlap course should be successful in completing the examination of the Registry and thus qualify for registration as an emergency medical technician—ambulance. This educational program is being developed and shortly will be available in the two-year colleges throughout the United States.

The guidelines for these activities have been developed by a joint committee of the Commission on Emergency Medical Services of the American Medical Association, chaired

†Basic training program for emergency medical technician-ambulance. Course guide and course coordinator orientation program. (Washington, D.C.; U.S. Government Printing Office, Jan. 1971.)

by I. E. Hendryson, M.D., and a committee of the American Association of Junior Colleges, chaired by Robert Love, M. Ed. A *Guide for Program Planning for Emergency Medical Service Technicians* has been published by the American Medical Association and is obtainable from the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610. This program envisions high school graduates, who are interested in the in-depth study of emergency medical care, spending at least two years in study, equaling approximately 60 semester credit hours, and who will take part in the general education course, the technical courses, and clinical experience designed to prepare the student for the range of emergencies he may expect to encounter. A basic course in general education covers communication skills, sociological and psychological insights, and the study of anatomy and physiology and the physical sciences. The technical courses include communications and record keeping, common first aid procedures, resuscitation, cardiopulmonary resuscitation, study of injuries, decontamination, metabolic disturbances, toxicology, medical asepsis, venipuncture and injection technics, understanding of childbirth, and the ability to maintain and operate sophisticated technical equipment. The two-year courses include clinical experience gained at the scene of emergencies, in the ambulance, in the hospital emergency room, and in the hospital's intensive care unit. The students are under the training and supervision of the responsible physician educator. The total program indicates larger portions of theory in the early stages and skill practice and theory applications increasingly throughout the later stages of the course.

This suggested curriculum is for the emergency medical service technician—ambulance. It is envisioned that other curricula will be developed for emergency medical service technicians who will work not only in the ambulance but in the hospital's emergency room, in intensive care units, in shock trauma units, in the communications system for emergency care, in mobile emergency unit vehicles, and other facilities as they are developed and manned. The training that is needed to develop the expertise for this profession is great. These emerging patterns of training truly offer a new career in the emergency care for the interested person. Many ex-corpsmen from the armed services, many individuals trained in practical nursing and other areas are finding these careers as an emergency medical technician—ambulance and as emergency medical technician, exciting ones to contemplate entering.

The Old Helping Hand Organization

Many of the younger doctors do not know that there exists in our state a unique helping hand organization, known as the Society for the Relief of the Widows and Orphans of Medical Men in New Jersey. This organization provides immediate financial assistance to the dependents of a deceased member. It lends money without interest to assist widows and orphans of doctors who have known adversity.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-
3-one.

ACTIONS: Methyltestosterone is an oil soluble androgenic hormone.

INDICATIONS: In the male: 1. Eunuchoidism and eunuchism. 2.
climacteric symptoms when these are seconlary to androgen deficie
3. Impotence due to androgenic deficiency. 4. Postpuberal cry
chidism with evidence of hypogonadism.
Cholestatic hepatitis with jaundice and altered liver function tests,
as increased BSP retention and rises in SGOT levels, have been repo
after Methyltestosterone. These changes appear to be related
dosage of the drug. Therefore, in the presence of any changes in
function tests, drug should be discontinued.

PRECAUTIONS: Prolonged dosage of androgen may result in sodium
fluid retention. This may present a problem, especially in pati
with compromised cardiac reserve or renal disease. In treating
for symptoms of climacteric, avoid stimulation to the point of incr
ing the nervous, mental, and physical activities beyond the pati
cardiovascular capacity.

CONTRAINDICATIONS: Contraindicated in persons with known or
pected carcinoma of the prostate and in carcinoma of the male bre
Contraindicated in the presence of severe liver damage.

WARNINGS: If priapism or other signs of excessive sexual stimula
develop, discontinue therapy. In the male, prolonged administratio
excessive dosage may cause inhibition of testicular function,
resultant oligospermia and decrease in ejaculatory volume. Use c
iously in young boys to avoid premature epiphyseal closure or
cocious sexual development. Hypersensitivity and gynecomastia
occur rarely. PBI may be decreased in patients taking androg
Hypercalcemia may occur, particularly during therapy for meta
breast carcinoma. If this occurs, the drug should be discontinued.

ADVERSE REACTIONS: Cholestatic Jaundice • Oligospermia and
creased ejaculatory volume. • Hypercalcemia particularly in pati
with metastic breast carcinoma. This usually indicates progressio
bone metastases. • Sodium and water retention. • Priapism • V
zation in female patients • Hypersensitivity and gynecomastia.

DOSAGE AND ADMINISTRATION: Dosage must be stricly individual
as patients vary widely in requirements. Daily requirements are
administered in divided doses. The following chart is suggested a
average daily dosage guide.

INDICATION	Average Daily Dos Tablets
In the male:	
Eunuchoidism and eunuchism	10 to 40
Male climacteric symptoms and impotence due to androgen deficiency	10 to 40
Postpuberal cryptorchism	30

HOW SUPPLIED: 5, 10, 25 mg. in bottles of 60, 250.

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NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

May 11 and May 15, 1973

Two regular meetings of the Board of Trustees were held during the 1973 Annual Meeting in Atlantic City. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

May 11, 1973

President's Appreciation . . . Received President D'Elia's expression of appreciation to the Officers and members of the Board for their assistance and kindness during his term.

New Jersey Health Care Council . . . Approved the report of the April 29th meeting of the New Jersey Health Care Council, including the following recommendations:

1. That an organization be established and officially known as the New Jersey Health Care Council.

2. That the purpose of the New Jersey Health Care Council be to safeguard and improve the delivery to the public of adequate, needed health care services of quality, in a manner consonant with the optimum efficiency of health profession activities.

3. That the Council members be the Executive Directors and Presidents, or their designated representatives, with alternates, of the various health care associations and that each organization be entitled to one vote. (Executive Directors are to be ex-officio members of the Council, without vote.)

New Jersey Foundation for Health Care Evaluation . . . Received, with commendation, a report from the Core Committee of the New Jersey Foundation for Health Care Evaluation, outlining its activities which revealed that the Bylaws and Articles of Incorporation for the Foundation had been prepared; that meetings had been held with the specialty societies toward establishing norms of medical care for institutional services, and developing relative value indices for the Foundation in preparing a screening mechanism for review of established usual and customary fees; that local mechanisms for peer review were being developed along with an educational program to familiarize physicians with the procedures; that a budget had been prepared for one year; and that Thomas J. Crane had been engaged as administrator of the Foundation, effective April 16, 1973.

AMA Delegates . . . Directed that the Chairman of the Nominating Committee be instructed to read to the members of the Nominating Committee a memorandum to the effect that if the current policy of sending all alternate delegates to AMA meetings is to be continued, alternate delegates be given first preference in the process of nominating and electing AMA delegates.

Chiropractic Suit in Bergen County . . . Received notification that MSNJ has been joined as a party defendant in the litigation between Bergen-Passaic Chiropractic Association and the Bergen County Medical Society and that Chubb and Son will defend the Society. (see page 491, June 1973 *Journal*).

MSP Board of Trustees . . . Referred the submitted nominees for terms on MSP's Board of Trustees to the 1973 House of Delegates (see page Tr 24 July 1973 *Journal*).

May 15, 1973

Introduction of New Members . . . Welcomed Meyer L. Abrams, M.D., 4th District, and David R. Brewer, Jr., M.D., 5th District, as members of the Board of Trustees.

. . . Noted that John S. Madara, M.D., was elected to the office of Second Vice-President; that Louis F. Albright, M.D., was re-elected to the office of Secretary; and that Samuel J. Lloyd, M.D., was re-elected to the office of Treasurer.

Reorganization of Board . . . Elected Nicholas E. Marchione, M.D., Chairman of the Board for 1973-1974; re-elected David Eckstein, M.D., Secretary of the Board for 1973-1974; agreed to continue to meet regularly at 10:45 a.m. on the third Sunday of each month in the Executive Offices (meetings subject to cancellation should the agenda prove insufficient); re-elected I. Edward Ornaf, M.D., as Board of Trustees member on the Committee on Finance and Budget for a three-year term (1973-76); and re-elected A. Guy Campo, M.D. and Frederick W. Durham, M.D. to membership on the Committee on Physicians' Relief Fund for three-year terms (1973-1976).

Nominating Procedure . . . Referred to the Secretary for implementation a recommendation from the *ad hoc* committee that the procedure called for in the following approved recommendation be reviewed in terms of its practicability and usefulness and reported thereon to the House of Delegates after the first year of operation:

That all candidates for office to be dealt with by the Nominating Committee be identified as candidates for the specific offices by official communication to the secretary of MSNJ submitted no later than March 31, together with completed informational data sheets which will be supplied in advance by the Secretary to secretaries of all component societies. This procedure will not affect nominations from the floor.

Format of Payment Vouchers Under Medicare . . . Directed that Resolution #12 (1973 House of Delegates), which requests the Prudential Insurance Company to improve methods for the submission of individual "Explanation of Benefits" data for each patient, be referred to the Council on Medical Services.

Fitness for Licensure . . Directed that Resolution #18 (1973 House of Delegates) which requests investigation and clarification of regulations and conditions under which a physician may be called for a hearing concerning his license to practice medicine and surgery in New Jersey, be referred to Legal Counsel for study of the laws pertaining to licensure, as reflected in the resolution, and report back to the Board.

Medicaid Waiver Project . . . Directed that in consideration of Resolution #25 (1973 House of Delegates) which opposes the Medicaid Waiver Project as presently constituted, MSNJ, in cooperation with the Essex County Medical Society and other interested associations, including HEW, the AMA, and the North Jersey Medical Association, meet promptly with the State Departments of Health and Institutions and Agencies, and that the Commissioner of Health, the Commissioner of Institutions and Agencies, the Director of the Medicaid Waiver Project, and the Governor be so notified of this action and supplied with a copy of Substitute Resolution #25.

Apportionment of MSNJ Delegates . . . Empowered the President to appoint an *ad hoc* committee to study, with the assistance of a statistician, the matter of apportionment of MSNJ Delegates and prepare a report for presentation at the Fall Conference of Presidents. In consequence of the action of the House of Delegates in adopting an amendment to Chapter 1, Section 4 of the Bylaws, current associate members automatically become active members: at the present ratio of one delegate for each twenty members of a component society, the total number of delegates would exceed the 400 permitted by the Constitution. The members of the *ad hoc* committee are: Meyer L. Abrams, M.D., Willingboro, Charles L. Cunniff, M.D., Jersey City, William J. D'Elia, M.D., Neptune City, John S. Madara, M.D., Salem, and James S. Todd, M.D., Ridgewood.

Women Physicians' Speakers Bureau

The New Jersey Medical Women's Association has a roster of members who are available for public talks, arranged by specialty and geographic location. For a copy of this roster, write to Dr. Satty Keswani, 176 West Mt. Pleasant Avenue, Livingston 07039.

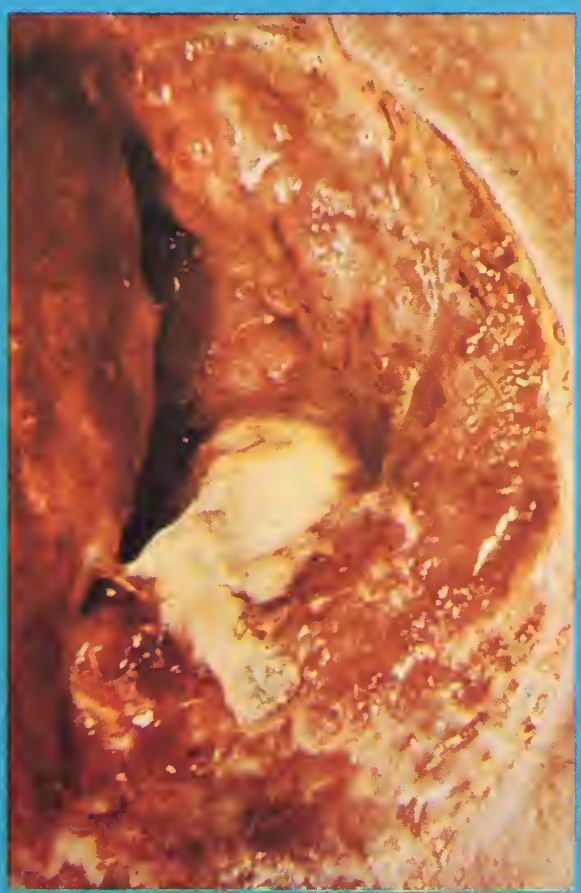
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Travase® Ointment

brand of **Sutilains**



Before treatment, necrotic matter coated the inner surfaces of this decubitus ulcer.



After six days of TRAVASE therapy, debridement is nearly complete and granulation evident.

ctive Therapy—Observe Its Effects in 48 hours
the recommended nursing technique is
ed without deviation, this procedure can
ate visible improvement within 48 hours of
ient. If no dissolution of slough occurs by then,
r application is unlikely to be rewarding
ck for break in procedure, usually due to use
ansing or antiseptic agents which impair the
veness of the enzyme in TRAVASE).

l observation and photos by Kathleen Brough
, M.D., Marion County Home, Indianapolis, Ind.

see next page for prescribing information

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ravase® Ointment brand of Sutilains

PLICATION TECHNIQUE: TRAVASE Ointment is indicated as an adjunct
established methods of wound care for biochemical debridement. It
solves and facilitates the removal of necrotic tissues and purulent
dates.

AVASE enzymes are selective. Virtually inactive on viable tissue.

en this recommended nursing technique is followed without deviation,
procedure can generate visible improvement within 48 hours . . .



being irrigated)
ghly cleanse and
e the wound area using
terile water or sodium
de solution. Be sure to
e the wound of any
ptics or heavy-metal
cterial agents which
terfere with the
e activity.

Thoroughly soak the wound area. Where practical, tubbing or showering is suitable. Or wet soaks with gauze pads may be used. Remember to avoid chemical cleansing agents which may interfere with the therapy.

With a sterile cotton swab or finger cot, apply a very thin layer of TRAVASE Ointment. The ointment spreads easily and only a small amount is needed (a small dab of ointment will cover an area as big as the back of a hand).

Be sure, though, to rub the ointment well into every crack or crevice of the wound and overlap the surrounding skin one-fourth to one-half inch beyond the area to be debrided—to be sure of complete coverage.



loose, wet dressings,
ghly soaked in sodium
de solution or sterile
to the area to be
led only.

Cover the moist dressings with an occlusive wrap (Saran wrap, Telfa Pads, or other plastic wrappings) to keep wound site moist. Do not extend occlusive wrap over ½ inch beyond area to be debrided.

When changing dressing, gently wipe away the dissolved material. Repeat the complete dressing procedure, including application of TRAVASE Ointment, four times daily.

ulcer shown in these photos is simulated on a model in order to demonstrate orrect TRAVASE application technique.

: FLINT LABORATORIES
Division of Travenol Laboratories, Inc.
200 Wilmot Road
Deerfield, Illinois 60015

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ase send:

___ Additional Information on TRAVASE® Ointment (brand of Sutilains)

___ In-service training program

___ Comment _____

DESCRIPTION: TRAVASE® (brand of sutilains) Ointment is a sterile preparation of proteolytic enzymes, elaborated by **Bacillus subtilis**, hydrophobic ointment base consisting of 95% white petrolatum and polyethylene. One gram of ointment contains approximately 82,000 units* of proteolytic activity.

ACTION: TRAVASE Ointment selectively digests necrotic soft tissues proteolytic action. It dissolves and facilitates the removal of necroti tissues and purulent exudates that otherwise impair formation of granulation tissue and delay wound healing (4).

At body temperatures these proteolytic enzymes have optimal activit the pH range from 6.0 to 6.8.

INDICATIONS: For wound debridement (1,2)—TRAVASE Ointment is indicated as an adjunct to established methods of wound care for biochemical debridement of the following lesions:

Second and third degree burns,
Decubitus ulcers,
Incisional, traumatic, and pyogenic wounds,
Ulcers secondary to peripheral vascular disease.

CONTRAINDICATIONS: Application of TRAVASE (brand of sutilains) Ointment is contraindicated in the following conditions:

Wounds communicating with major body cavities,

Wounds containing exposed major nerves or nervous tissue,

Fungating neoplastic ulcers,

Wounds in women of child-bearing potential—because of lack o laboratory evidence of effects of TRAVASE upon the developing

WARNING: Do not permit TRAVASE Ointment to come into contact the eyes. In treatment of burns or lesions about the head or neck, s the ointment inadvertently come into contact with the eyes, the eyes be immediately rinsed with copious amounts of water, preferably ste

PRECAUTIONS: A moist environment is essential to optimal activity enzyme. Enzyme activity may also be impaired by certain agents. In several detergents and antiseptics (benzalkonium chloride, hexachlorophene, iodine, and nitrofurazone) may render the substra indifferent to the action ot the enzyme (3). Compounds such as thim containing metallic ions interfere directly with enzyme activity to a slight degree, whereas neomycin, sulfamylon-streptomycin, and peni do not affect enzyme activity. In cases where adjunctive topical the has been used and no dissolution of slough occurs after treatment TRAVASE Ointment for 24 to 48 hours, further application, because interference by the adjunctive agents, is unlikely to be rewarding.

In cases where there is existent or threatening invasive infection, appropriate systemic antibiotic therapy should be instituted concurr

Although there have been no reports of systemic allergic reaction in humans, studies have shown that there may be an antibody respons humans to absorbed enzyme material.

ADVERSE REACTIONS: Adverse reactions consist of mild, transient paresthesias, bleeding and transient dermatitis. Pain usually can be controlled by administration of mild analgesics. Side effects severe enough to warrant discontinuation of therapy occasionally have occ

If bleeding or dermatitis occurs as a result of the application ot TRA (brand of sutilains) Ointment, therapy should be discontinued. No s toxicity has been observed as a result of the topical application of TRAVASE Ointment.

Dosage and Administration

STRICT ADHERENCE TO THE FOLLOWING IS REQUIRED FOR EFF RESULTS OF TREATMENT

1. Thoroughly Cleanse and Irrigate Wound Area with sodium c or water solutions. Wound **MUST** be cleansed of antiseptics heavy-metal antibacterials which may denature enzyme or a substrate characteristics (e.g., Hexachlorophene, Silver Nitr Benzalkonium Chloride, Nitrofurazone, etc.).
2. Thoroughly moisten wound area either through tubbing, sho or wet soaks (e.g., sodium chloride or water solutions).
3. Apply TRAVASE Ointment in a thin layer assuring intimate with necrotic tissue and complete wound coverage extendi ¼ to ½ inch beyond the area to be debrided.
4. Apply loose wet dressings.
5. Repeat entire procedure 3 to 4 times per day for best result

How Supplied

3P3002 TRAVASE Ointment is supplied sterile in one-half ounce t (14.2 g.) containing 82,000 casein units of sutilains per g hydrophobic ointment base.

The ointment must be stored under refrigeration at 2° to 10° C (35° to 50° F).

References

1. Garrett, T. A. **Bacillus subtilis** protease, a new agent for debride Clin. Med. 76: 11-15, 1969.

2. Hesterberg, R. (Necrosis treatment on fermentative basis). Docto dissertation from the Chirurgical Clinic of the University ot Munich. Dissertation Printing: Charlotte Schoen, Munich, 1964. (Ger.)

3. Howes, E. L. The healing ot the burn may be hindered by its first therapy. 20th Cong. Soc. Inter. Chir., Rome, Italy, September 14-23,

4. Prytz, B., Connell, J. F., Jr., and Rousselot, L. M. **Bacillus subtili** protease in the digestion of burn eschar. Clin. Pharmacol. Therap. 7 347-51, 1966.

*A casein unit is the amount of enzyme required to produce the sam optical density at 275 mμ as that ot a solution ot 1.5 mcg. tyrosine after the enzyme has been incubated with 35 mg. of casein at 37° one minute.

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Traffic Guide Through No-Fault Auto Insurance

(The following has been prepared by Richard M. Ball, M.D., practicing orthopedic surgeon and clinical instructor at Rutgers Medical School, CMDNJ.)

If you are practicing in New Jersey and treat patients injured in automobile accidents, then you and your office staff already have had to deal with the new New Jersey No-Fault Law. This became effective on January 1, 1973. Have you had a private medical insurance claim form returned, stamped "Benefits Denied—Motor Vehicle Accident? Or, conversely, has an auto insurance claim been rejected, marked "PIP (Personal Injury Protection) Benefits Do Not Apply?" If so, count yourself among the many other physicians still grappling with the vagaries of the new No-Fault law.

Basically the provisions are straightforward. Your patient is covered by No-Fault if he was injured as a pedestrian by a private automobile or while riding in a private passenger vehicle. If your patient owns a car or lives with another family member who owns a car then *his own* auto insurance covers, even though his own car was in the garage at the time of the accident. Thus his insurance follows him wherever he goes. If your patient does *not* own a car (or live in the same household with a family member who owns a car), then the other driver's auto insurance picks up the claim provided the other car was not a commercial vehicle (bus, taxi, truck) or a motorcycle. Also, if your patient was riding a motorcycle he may not recover from No-Fault policies even though he may have been struck by a private passenger auto. Of course, we are talking about cars registered in the State of New Jersey although the protection is valid no matter where the car is at the time of injury.

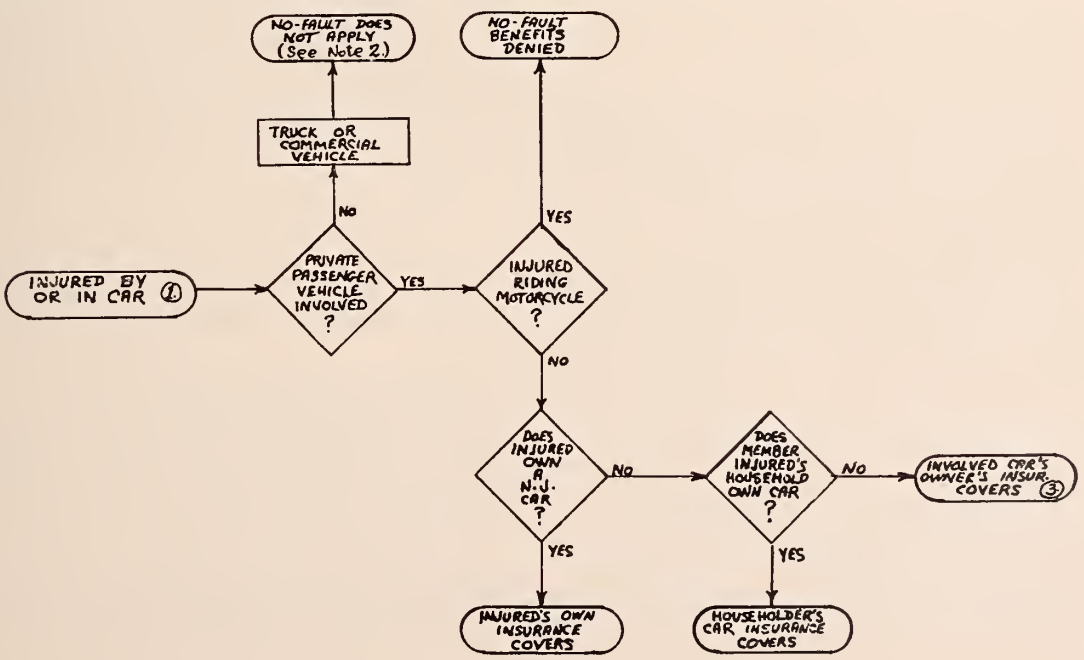
To help your insurance aide to decide whether to ask for the patient's Blue Shield card or for his automobile insurance ID card, the accompanying flow chart will be helpful. Just start at the lefthand end, "Injured By Or In Car" and follow the appropriate branches. Numbers on the chart refer to notes, below.

---

1. Car must be registered in New Jersey.

2. Limited benefits may nonetheless be available through patient's own auto insurance.

3. If more than one "other car," claims may have to be filed with all "other cars."



Therapeutic Drug Information Center

The New Jersey Regional Pharmaceutic and Therapeutic Drug Information Center, located at the Valley Hospital, Ridgewood, New Jersey, serves as a source of information on specific problems, articles, and reports concerning pharmaceutic and therapeutic information. A specialized library maintained by the Center contains complete information about U.S., foreign, investigational, and proprietary drugs, including their identification, availability, interactions, compatibility, side effects, dosage, adverse reactions and so on.

The Center is staffed by trained pharmacists. Jack M. Rosenberg, Pharm. D., Associate Professor of Pharmacy and Director of Drug Information, Brooklyn College of Pharmacy, LIU, serves as Consultant Director. Salvatore Peritore, M.S., serves as Project Director, and Kenneth Anderson, Assistant Project Director. The service is provided free, open seven days a week, and is available by telephone—(201) 445-4900, extension 304. To date, over 2,000 questions have been received by the Center, the majority from physicians. Below are three questions and answers handled by the Center recently.

1. Do you have any information regarding methyldopa in the treatment of Raynaud's disease and phenomenon?

Methyldopa (Aldomet) was reported to cause an improvement in 11 of 15 patients treated for primary Raynaud's disease and 20 of 27 patients treated for secondary Raynaud's phenomena without producing any serious or irreversible side effects.[1]

The administration of 1 to 2 Grams daily was frequently effective in:

1. Preventing episodes of Raynaud's phenomenon during both experimental cold exposure and normal wintertime exposure.

2. Improving the blood supply to the digital skin during cold exposure.

3. Increasing the rate of rewarming of digits after cold exposure.

4. Relieving chronic pain in the fingers, which occurred in ambient temperatures above 25 C.

Current Therapy[2] mentions methyldopa as a promising drug for the treatment of Raynaud's phenomenon. It also stated that "Since no serious or irreversible side effects should be expected unless very heavy doses are prescribed, this drug is preferred initially in those patients who have fairly marked signs and symptoms."

References: 1. Veradi, D.P. and Lawrence, A. M.: "Suppression of Raynaud's Phenomenon by Methyldopa," *Arch Intern Med*, 124:13 (1969)

2. Conn, H. F.: *Current Therapy*, Saunders, Philadelphia, 1972, p. 210

2. What are the current recommendations for using isoniazid as a prophylaxis against tuberculosis?

The Center for Disease Control, Atlanta, Georgia, recommends that priority efforts should be made to identify and treat individuals in the following groups:

1. Members of the household of a newly diagnosed case of tuberculosis, regardless of tuberculin status. Preventive treatment of these household contacts should continue for a full year, even when exposure to the infectious case has ended and tuberculin tests remain negative. Preventive treatment of negative reactors should be given other persons who have had close, extended exposure comparable to that of a person living in the same household with an active case.

2. Persons known to have recently become infected, i.e., converted from negative to positive tuberculin reaction. A converter is defined as an individual who has had a "substantial" change in his tuberculin reaction, from below 10 millimeters to above 10 millimeters, in the last two years. "Substantial" is arbitrarily defined as a change of 6 millimeters or more.

3. Positive tuberculin reactors with "pulmonary fibrosis" or old fibrotic lesions presumably tuberculous in origin, former tuberculosis patients who have never had specific chemotherapy or who have had inadequate drug therapy (e.g., treatment for less than 18 months, no isoniazid, etc.). At particularly high risk are persons with pulmonary lesions of unknown etiology, compatible with tuberculosis, in which active disease has been excluded.

4. Tuberculin reactors in certain clinical situations known to lessen their resistance to disease: prolonged corticosteroid treatment, gastrectomy, leukemia, silicosis, Hodgkin's disease, pneumoconiosis, severe or poorly controlled diabetes, pregnancy, and children with measles or whooping cough. In the case of pregnant women, treatment should be started in the last trimester.

5. Children who are reactors through the age of adolescence.

6. School personnel and other adult reactors closely associated with children.

As of January 23, 1973, the CDC has added one further provision:[2]

Until further information about the relation of alcohol and isoniazid-associated hepatotoxicity is developed, it is recommended that alcoholics who have been infected with the tubercle bacillus but who do not have abnormal chest films or any other risk factors should not be given preventive treatment with isoniazid.

The dose of isoniazid for prophylaxis is 300 mg per day for adults and 10 mg per Kg body weight for children not to exceed 300 mg per day, to be administered daily for a period of 12 months.

References: 1. ***Morbidity and Morality Weekly Report,*** Vol. 18, No. 18 (May 3) 1969

2. Miller, J. D.: Liver Disease Among Recipients of Isoniazid Chemoprophylaxis Under Special Surveillance—Follow-up Report, Memo from Center for Disease Control, Atlanta, Georgia (January 23) 1973

3. What different insulin preparations can be mixed together in the same syringe or vial?

1. Regular insulin may be added to NPH insulin in any ratio, but the mixing should be done immediately prior to use in order to prevent changes that may lead to unpredictable time activities of the combination.

2. Regular insulin may be added to Lente insulin and the time activity of each preserved if the ratio of regular insulin to Lente does not exceed 1:1. If, in a given dose, the amount of regular insulin exceeds that of Lente, physicochemical changes due to the differences in pH of the two insulins may result in an unpredictable time-activity curve of the combination. Like the NPH-regular combination, the regular-Lente mixture should be used immediately after its preparation.

3. Regular insulin may be added to Protamine Zinc insulin, but because of the excess of protamine in Protamine Zinc insulin, mixtures of regular and Protamine insulin in a ratio of less than 1:1 may have the same time activity as Protamine Zinc insulin alone. As the proportion of regular to Protamine Zinc insulin nears 2:1, a time-activity curve approximating that of NPH insulin is obtained. When the ratio exceeds 2:1 (i.e., the amount of regular insulin is increased further), the time activity of the mixture approaches that of a regular-NPH combination. Mixtures of regular and Protamine Zinc insulin may be prepared at any time.

4. Semilente, Ultralente, and Lente insulin may be combined in any ratio. Their combination differs from the regular-Lente or regular-NPH mixture in that it can be made at any time. The physician may prepare the mixtures during patient visits for those who require combination of the Lente triad but who are incapable of preparing it themselves.

References: 1. Waife, S. O.: *Diabetes Mellitus,* Seventh Edition, Lilly Research Laboratories, Indianapolis, Indiana, 1967, p. 88

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President, CMDNJ

More of this year's College of Medicine and Dentistry of New Jersey graduates have decided to intern in New Jersey than ever before. Twenty-seven of the New Jersey Medical School's May graduates chose New Jersey hospitals. An additional twelve participants in the College's "Fifth Channel" program, a nine-month clinical training project for foreign medical alumni headquartered at Rutgers Medical School, also elected to remain in New Jersey hospitals as interns and residents. This is good news for New Jersey when you consider that most of the 41 new interns have cast their lot with us now and more than likely will remain in our state to practice after completion of their internships.

Of the 108 graduates this year, 95 participated in the 1973 National Intern and Resident Matching Program. Of these, 67 per cent received their first choice and 14 per cent their second choice. This performance suggests that the increasing success of New Jersey Medical School graduates in the matching program shows the growing prominence of our school in the eyes of other medical institutions.

Another gratifying fact is that *all* of our graduates will be interning at university-affiliated hospitals. Sixteen of these have chosen our primary teaching hospital in Newark, Martland Medical Center. By contrast with previous years, Martland fared well in the program with 48 of its 55 openings filled. This stands out in sharp contrast with 1970 when only 13 of 59 available places were filled through the matching program.

New Jersey hospitals selected by the "Fifth Channel" program participants include Martland and St. Michael's in Newark, Muhlenberg in Plainfield, Jersey City Medical Center, Overlook in Summit, St. Joseph's in Paterson, and Middlesex General in New Brunswick. We look forward to an even better performance next year when, in addition to 113 New Jersey Medical School alumni, 32 graduates of the first four-year class at the Rutgers Medical School will be added to our potential intern pool.

New Jersey Medical School graduates will intern at Overlook Hospital in Summit, St. Michael's Hospital in Newark, Monmouth Medical Center in Long Branch, St. Barnabas Medical Center in Livingston, and Hunterdon Medical Center in Flemington.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

INTERNAL MEDICINE—M.I.A. Malik, M.D., 226 Lincoln Avenue, Apt. 17, Newark 07104. King Edward (India) 1962. Board eligible. Subspecialty, pulmonary disease. Group, partnership, or associate. Available.

L. A. Samarsinghe, M.D., c/o Englewood Hospital, Englewood (NJ) 07631. Board eligible. Hospital in northern New Jersey, Available.

William Dutchen, M.D., 1272 Grand Concourse, Bronx, New York 10456. NYU 1943. Board certified. Group, partnership, hospital. Available.

Arvino C. Mehta, M.D., Empire House, S.V. Road, Irla, Ville Parle, Bombay 56, India. University of Bombay 1957. Subspecialty, neurology. Group or partnership. Available.

Satish Chawla, M.D., 61-15 98th Street, 15-B, Rego Park, Queens, New York 11374. India Institute of Medical Sciences 1965. Board certified. Partnership or solo. Available January 1974.

George E. Berk, M.D., Ridder Apts. 4-5, 3-D, Valley Road, Manhasset, New York 11030. Cornell 1968. Board eligible. Subspecialty, cardiology. Group, solo, or partnership. Available July 1974.

Albert A. Maniscalco, M.D., 5300 Shady Bluff Street, Durham, North Carolina 27704. New York Medical 1966. Board certified. Subspecialty, nephrology. Group partnership, full-time hospital. Available July 1974.

NEUROLOGY—Bruce D. Snyder, M.D., 160 W. Montgomery Avenue, Ardmore, Pennsylvania 19003. Johns Hopkins 1968. Board eligible. Group, academic, or solo. Available July 1974.

OPHTHALMOLOGY—Richard A. Getnick, M.D., 400 Gypsy Lane, Apt. 520, Philadelphia, Pennsylvania 19144. Yale 1968. Group or partnership. Available July 1974.

ORTHOPEDICS—Tara K. Nigam, M.D., 308-353 Tache Avenue, Winnipeg, Manitoba, Canada, R2H 2A6. Lucknow (India) 1963. Board certified. Group or partnership. Available November 1973.

PATHOLOGY—Saramma John, M.D., 83-83 118th Street Apt. 3H, New York 11415. Trivandrum (India) 1964. Board certified. Hospital or group. Available.

Rosina M. Salazar, M.D., St. Vincent's Hospital, 153 West 11th Street, New York 10011. University of East Ramon (India) 1966. Board eligible. Assistant. Available.

PEDIATRICS—Chang T. Lin, M.D., 783 Remsen Avenue, Brooklyn, New York 11236. Kaohsiung (Taiwan) 1966. Board eligible. Group. Available.

Rohit K. Shah, M.D., 225 St. Paul's Avenue, Apt. 16E, Jersey City 07306. B. J. Medical College (India) 1965. Board eligible. Group or partnership. Available.

K.N.P. Krishnaraj, M.D., 33 Terrace West, Plattsburgh, New York 12901. Stanley Medical College (India) 1961. Board eligible. Hospital, group, partnership, or solo. Available, September 1973.

Sheela Kapoor, M.D., 29 Pennsylvania Avenue, Stratford (NJ) 08084. K.G. Medical College (India) 1962. Board certified. Group, partnership, or solo. Available.

PSYCHIATRY—Bohdan Cehelyk, M.D., 1217 Medary Avenue, Philadelphia, Pennsylvania 19141. Hahnemann 1970. Group, partnership, or salaried position with opportunity for private practice. Available July 1974.

SURGERY—Edgar T. Victoria, M.D., 1420 Arch Street, Norristown, Pennsylvania 19401. Manila Central University 1966. Group association, full time hospital. Available.

Arnold H. Herman, M.D., 71 Davis Road, Westover AFB, Massachusetts 01022. University of Kansas 1966. Board eligible. Subspecialty, vascular surgery. Association or group. Available July 1974.

Limitation on Amphetamines

The State Commissioner of Health, in cooperation with the United States Food and Drug Administration and the Department of Justice, Bureau of Narcotics and Dangerous Drugs, issued the following information regarding the status of drugs containing amphetamine and amphetamines in combination.

Effective March 30, 1973, the following amphetamine-type products may no longer be legally marketed, distributed, or dispensed and are subject to recall.

(1) Any combination of amphetamines (and their salts) with other ingredients such as tranquilizers, sedatives, rauwolfia derivatives, vitamins, and so on.

Included under the above provisions are "Desbutal" capsules and gradumets (Abbott Laboratories); "Obedrin-LA" and "Obedrin" (Beecham-Massengill).

However, the provisions do *not* apply to *oral* preparations consisting of amphetamine and/or dextroamphetamine (and their salts) alone or in combination with each other. Single entity *oral* methamphetamine preparations are also excluded.

(2) All parenteral injections of amphetamines and methamphetamines.

(3) Levamphetamine alone or in combination with other ingredients, such as: Cydril Granucaps, Cydril Tablets. (These are used in the management and treatment of obesity)

Controlled Substances subject to the recall are to be returned to the original supplier or manufacturer. Any Controlled Substance returned after June 30, 1973, will require the use of official order forms.

Geriatric type substances containing amphetamines, vitamins, and hormones, (such as Mediatric Capsules, Tablets, or Liquid) are not subject to recall. Any geriatric products containing amphetamines and vitamins without hormones are subject to the recall.

Some pharmaceutical firms have reformulated their products deleting the amphetamine ingredient and they are marketed under their existing trade names. Physicians, pharmacists, and wholesalers are urged to read the labels. Old stocks which do contain amphetamine are still subject to recall and/or appropriate disposition.

Manufacturers of several drugs have requested exemption from the provisions of this recall. Until such time as the Food and Drug Administration and the Federal Bureau of Narcotics and Dangerous Drugs have resolved the claims by procedural hearings, the following drugs are *not* subject to the recall provision above:

Obetrol, 10 to 20 milligram tablets
Oby-Rex
Eskatrol spansules
Dexamyl, all forms
Bamadex, sequels only
Delcobese tablets, sustained release tablets, capsules, sustained release capsules
Amphaplex
Saccamine

Questions or assistance regarding this may be directed to Donald J. Foley, Chief, Drug Control Program, Division of Narcotic and Drug Abuse Control, 109 West State Street, Trenton, New Jersey— (609) 292-5277.

Tribute to Richard I. Nevin

(Salem County Medical Society—May 19, 1973)
John S. Madara, M.D.*

I have often jestingly referred to Mr. Richard Ignatius Nevin as "King Richard." There's a line in Shakespeare's play, *King Richard III*, that says, "His better doth not breathe upon the earth." There's no line that seems more apropos at this time. For Richard Nevin has served The Medical Society of New Jersey with his heart, soul, strength, and mind as its Chief-of-Staff for the past 23 years. He has been an advisor and counsellor to many, if not most, of its officers (including some of its own Judicial Councilors). He has spoken and written eloquently for and about our profession. He has diagnosed our ills perhaps better than we have diagnosed his. He has been a friend to medicine, and a dear friend to many physicians. And so it can truly be said, as an executive director, counsellor, orator, writer, and friend, "His better doth not breathe upon the earth."

And to his better half, Del, who has become endeared to all who know her, we wish many more years of togetherness, realizing that our loss is her gain. To both of you we give our heartfelt thanks for over two decades of devotion.

Please accept this picture as a token of our esteem, and a remembrance of those who practice medicine in the county of shad and muskrat.

May God bless you both real well.

*Dr. Madara is Second Vice-President of MSNJ.

ANNOUNCEMENTS

Conference on Diagnostic Ultrasound

A B-Scan Ultrasound Conference will be held on September 7, 1973, at Johns Hopkins Hospital in Baltimore. This is designed for radiologists, obstetricians, and nuclear medicine specialists interested in diagnostic ultrasound. It will be of particular value to doctors and technologists contemplating ultrasound scanning or who have recently started B-scan ultrasound. Since B-scan ultrasound machines may, in addition, be used for echocardiography and echoencephalography, these topics will be considered. Faculty will include G. Leopold, W. Cochrane, and S. Uematso. Details can be obtained from R. C. Sanders, M.D., Department of Radiology, Johns Hopkins Hospital, Baltimore, Maryland.

Graduates Lectures in Surgery

The following programs have been announced for the 1973-1974 "Distinguished Lecture Series" offered by the Department of Surgery of the New Jersey Medical School, CMDNJ:

September 10	Kidney Transplantation in Man Samuel L. Kounts, M.D., Chairman Department of Surgery, SUNY
October 1	Neurosurgical Treatment of Pain Abbot J. Crieger, M.D., Assistant Professor of Neurological Surgery University of Pittsburgh School of Medicine
December 10	Hiatus Hernia G. Robert Mason, M.D., Chairman Department of Surgery University of Maryland School of Medicine
January 28	Benign Lesions of the Breast William T. Fitts, Jr., M.D., Chairman Department of Surgery University of Pennsylvania School of Medicine
February 11	Metastatic Tumors of the Lung Paul C. Adkins, M.D., Chairman Department of Surgery George Washington University School of Medicine

Lectures are held at 4 p.m. in the amphitheater, 2nd floor, Martland Hospital, Newark. There is no charge. Guarded parking is available in parking lot M, 12th and Bergen Streets. The November lecture (orthopedics) will be announced in a later issue. For further information, please write to Eric J. Lazaro, M.D., Professor of Surgery, Martland Hospital Unit, CMDNJ, 65 Bergen Street, Newark 07107.

Pulmonary Disease Program in East Orange

The Veterans Administration and the College of Medicine and Dentistry of New Jersey are cosponsoring a program of grand rounds and lectures on pulmonary disease. These will be held on Wednesdays at 11:30 a.m. in the third floor auditorium of the Veterans Administration Hospital in East Orange.

September 19	Current Diagnostic Criteria for Bronchitis, Asthma, and Emphysema
October 10	Flow-Volume Loop Curves in Diagnosis of Pulmonary Disease
November 21	Big ACTH: Possible Biologic Marker in Pulmonary Carcinoma
December 19	Role of Respiratory Muscles in Respiratory Failure
January 16	Respiratory Phenomena Accompanying Metabolic Acidosis and Related States
February 29	Approach to the Patient with Diminished Resistance to Pulmonary Infection
March 20	Immunotherapy with BCG
April 17	Management of Respiratory Failure
May 15	Transfer Factor and Its Use in Bacterial and Fungal Infection

For further information, please write to L. Fred Ayvazian, M.D., Chief of Pulmonary Disease Section, Veterans Administration Hospital, East Orange, New Jersey.

Middlesex General Hospital Postgraduate Lectures

Following is the schedule of lectures in the postgraduate course to be held at the Mid-

dlesex General Hospital (180 Somerset Street, New Brunswick) September 1973 through May 1974. Lectures are given on Wednesdays from 9 to 11 a.m. on the dates indicated.

September 26	Total Management of Arthritic Patient George E. Ehrlich, M.D.
October 3	Office Orthopedic Procedures Edward Resnick, M.D.
October 10	Current Concepts of Multiple Sclerosis Donald H. Silverberg, M.D.
October 17	Otological Problems in General Practice Max Ronis, M.D.
October 24	Neurological Examination Eli Goldensohn, M.D.
October 31	Management of Thromboembolism Sol Sherry, M.D.
November 7	Pressure Neuritis John H. Martin, M.D.
November 14	Unusual Infections Donald Louria, M.D.
November 21	Medical and Surgical Emergencies in Psychiatry Seymour Kuvin, M.D.
December 5	Current Views on Stroke Prevention and Management Fletcher McDowell, M.D.
December 12	Management of Acute Drug Intoxications Jerry L. Rosenbaum
December 19	Determinants of Emotional Health William L. Webb, Jr., M.D.
January 2	Dermatology and the Clinician 1974 James J. Leyden, M.D.
January 9	Hemoptysis Leon K. Cudkowicz, M.D.
January 16	Office Evaluation and Management of the New Hypertensive Patient Albert Sellers, M.D.
January 23	Medical Complications of Acute Myocardial Infarction Nicholas DePasquale, M.D.
January 30	Surgical Considerations in Management of Myocardial Infarction and its Complications Robert S. Litwak, M.D.
February 6	Hormones, Hypertension, and Vascular Disease Harvey Wolinsky, M.D.
February 13	Perspectives in Diabetes Charles Shuman, M.D.
February 20	Present Trends in Hyperalimentation Benjamin Rush, M.D.
February 27	Biological Role of the Lymphocyte Jerome I. Brody, M.D.
March 6	Paraneoplastic Syndromes W. P. L. Myers, M.D.
March 13	Neurological Complications of Systemic Cancer Jerome Posner, M.D.
March 20	Metabolic Bone Disease Ernest Schwartz, M.D.
March 27	Untoward Effects of Long-Term Steroid Therapy Nocholas P. Christy, M.D.
April 3	Practical Eye Care in Family Practice Frederick Sutliff, M.D.
April 10	Management of Gynecological Problems in Office Practice Michael Daly, M.D.
April 17	Emergencies of Pregnancy and Labor Gordon W. Douglas, M.D.
April 24	Pulmonary Function Testing M. Henry Williams, M.D.
May 1	Environmental Cancer in the Year 2000 Irving M. Selikoff, M.D.
May 8	Unusual Causes of Heart Failure and Their Management Hadley L. Conn, M.D.
May 15	Hemorrhagic and Septic Shock Peter Sigman, M.D.
May 22	New Developments in Infectious Diseases David J. Gocke, M.D.
May 29	ENT in Office Practice Myron J. Shapiro, M.D.

Cardiovascular Seminar in London

The Symposia Medica Foundation, in cooperation with the Royal Society of Medicine, will present an international seminar on cardiovascular disease, to be held in London, October 12 to 20, 1973. Registration fee is $100. For further information, please write to Ms. Cynthia V. Soika, Symposia Medica Foundation, 305 East 24th Street, Suite 17-F, New York 10010.

EENT for the GP

The University of Miami School of Medicine is presenting a course on "Otolaryngology for the Family Practitioner." The course will be held October 26 and 27, 1973, at the Playboy Plaza in Miami, Florida, and is accredited by the AAGP. For information write: Bruce W. Weissman, M.D., Department of Otolaryngology, University of Miami School of Medicine, P.O. Box 875, Biscayne Annex, Miami, Florida 33152.

Loeser Memorial Lecture

The second annual Lewis H. Loeser Memorial Lecture will be held Wednesday, November 14 at 8 p.m. at the East Orange Veterans Administration Hospital. Dr. Seymour S. Kety, Professor of Psychiatry, Harvard Medical School, and Director of Psychiatric Research Laboratories at Massachusetts General Hospital, will be the speaker. He will discuss

research in the schizophrenias. This lecture is sponsored by the Mental Health Association of Essex County as a memorial to Lewis H. Loeser, M.D., whose contributions to psychiatry and neurology in this state are well known.

Seminars at Sea

The Department of Mental Health Sciences of the Hahnemann Medical College, in conjunction with American Express, is sponsoring a Carribean Cruise combined with a continuing education experience scheduled for November 26 to December 4, 1973. The topic is "Psychodynamics of Sexual Therapies."

Courses for psychiatrists as well as other medical practitioners will be offered on mornings the ship is at sea, led by Hahnemann faculty and providing American Medical Association Category I credit. For further information write to: Dr. Richard Newman, Hahnemann Department of Mental Health Sciences, 314 North Broad Street, Philadelphia 19102.

Seminar on Pediatric Nephrology

From January 2 to 5, 1974, the University of Miami will offer a seminar on pediatric nephrology. Director of this colloquium is Jose Strauss, M.D., chief of pediatric nephrology at the University. The meetings will be at the Eden Roc Hotel in Miami Beach. Tuition is $125. Properly accredited residents will be accepted for $50 tuition fees. For more details write to University of Miami, P.O. Box 875, Biscayne Annex, Miami, Florida.

Pediatric Dermatology Symposium

February 22, 23, and 24, 1974, are the dates for the next symposium on skin disorders of children and adolescents. It will be held at the Fontainebleau in Miami Beach. Tuition is $125. Postgraduate training credit is given for this conference which is sponsored by Mt. Sinai Medical Center in Miami Beach. For more details, write to Department of Postgraduate Education, Mt. Sinai Medical Center, Miami Beach, Florida 33140.

INFORMATION FOR READERS AND CONTRIBUTORS

The Journal, the official organ of The Medical Society of New Jersey, is published monthly under the direction of the Committee on Publication. *The Journal* is released the first week of the month, and a copy is sent to each member of the Society.

Change of Address: Notice of change of address should be sent promptly to The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey, 08605.

Communications: Members are invited to submit to *The Journal* any suggestions for the welfare of the Society, as well as comments or criticisms of material in *The Journal.* All such communications should be directed to the Editorial Office of *The Journal.* The Publication Committee reserves the right to publish, reject, edit, or abbreviate all communications submitted.

Contributions: Manuscripts submitted to *The Journal* must be typewritten, *double-spaced* on letter size (about 8½ by 11 inch) paper, and forwarded to the Editorial Office at the address below. The Publication Committee expressly reserves the right to reject any contributions, whether solicited or not, and the right to abbreviate or edit such contributions in conformity with the needs and requirements of *The Journal.* Galley-proofs of edited or abbreviated manuscripts will be submitted to authors for approval before publication. Every care will be taken with the submitted material, but *The Journal* will not hold itself responsible for loss or damage to manuscripts. Authors are required to submit an original and one copy and are urged to keep a carbon for reference. It is understood that material is submitted here for exclusive publication in this *Journal.*

Illustrations: Authors wishing illustrations for their articles will submit glossy prints or original drawings from which cuts can be made. The cost of making such cuts will be borne by the author, who may, after publication, receive the cuts for his own use—*if he makes such a request* in writing to the Editorial Offices.

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

P. O. Box 904, Trenton, New Jersey 08605

OBITUARIES

Dr. Elizabeth Brakeley

One of the pioneer woman physicians of New Jersey, Elizabeth Brakeley, M.D., died on March 26, 1973. Born in 1894, she had for some years been in the U.S. Public Health Service as a major in the medical corps. In private practice, she was a pediatrician and, before retirement, was on the staff of the Mountainside Hospital in Montclair. Dr. Brakeley was an alumna of the Medical School of Cornell University, class of 1926. She was a member of our Essex County Medical Society.

Dr. John N. Connell

Born in 1896, John N. Connell, M.D., retired in 1968 and moved to Sea Girt but retained his membership in the Hudson County Medical Society. He received his M.D. at Columbia University's College of Physicians and Surgeons in 1920. Dr. Connell was a board diplomate in obstetrics and gynecology and for years was a service chief at the Margaret Hague Hospital in Jersey City. He was on the faculty of his alma mater and a Fellow of the American College of Surgeons. Dr. Connell was a 1970 recipient of the MSNJ Golden Merit Award.

Dr. Anthony D. Crecca

Scheduled to be elected to emeritus membership this year, Anthony D. Crecca, M.D., died just a few days before the Annual Meeting in May 1973. He had been born in 1908 and was a well-known thoracic surgeon. He had been on the staffs of St. Mary's Hospital in Orange, and both Columbus and St. Michael's Hospitals in Newark. Dr. Crecca was a Fellow of the American College of Surgeons and belonged to our Essex County Medical Society.

Dr. Abraham J. Gitlitz

Abraham J. Gitlitz, M.D., died on May 9, 1973, at the age of 67, as the result of a motor accident while vacationing in Bermuda. He was graduated from the College of Physicians and Surgeons of Columbia University in 1930 and devoted himself professionally to clinical pathology. In that capacity Dr. Gitlitz was affiliated with the Greenville, Fairmount, and Christ Hospitals in Jersey City and was a Fellow of the American College of Pathologists as well as a member of our Hudson County Medical Society.

Dr. Edward Glazer

A 1924 graduate of Tulane, Edward Glazer, M.D., of Elberon, died on November 6, 1972 at the age of 73. He was an anesthesiologist and was, indeed, director of anesthesiology at Monmouth Memorial Medical Center in Long Branch. He was also a Fellow of the American College of Anesthesiologists.

Dr. Harold S. Hatch

Born in 1891, Harold S. Hatch, M.D., died on May 2, 1973 at the age of 82. He was a 1914 graduate of the medical school of the University of Vermont. He was an internist, and a Fellow of the American College of Physicians and the American College of Chest Physicians. He was an emeritus member of our Morris County Component Society and had been director of the Shonghum Mountain Sanatorium. He was on the staffs of both Morristown Memorial Hospital and All Souls Hospital in Morristown.

Dr. Harry Horn

A 1925 graduate of the Medical School at Tufts University, Harry Horn, M.D., died on April 29, 1973. He had been born with the century and was 73 at the time of his death. Dr. Horn was an otolaryngologist and ophthalmologist who had served on the staffs of Newark Beth Israel Hospital and Irvington General Hospital. During World War II, he was a major in the medical corps on duty in Africa. He was a member of the Essex County Medical Society and a Fellow of the New Jersey Academy of Medicine.

Dr. Barnett Kooperman

The Journal has just been apprised of the death in July 1971 of Barnett Kooperman, M.D., a long-time member of the Hudson County Medical Society. Born in 1890, he was a 1914 graduate of the old Long Island College of Medicine. He was a family doctor in West New York, who had retired in 1955. Dr. Kooperman was living in Walden, New York at the time of his death.

Dr. Arthur Kraut

Arthur Kraut, M.D., died on June 14, 1973, at the age of 76. He was a well-known Jersey City psychiatrist and neurologist, an active amateur author and versifier, and one of this year's Golden Merit Award laureates. Dr. Kraut was affiliated with the neurologic and psychiatric services at St. Mary's Hospital in Hoboken, Christ Hospital in Jersey City, and the North Hudson Hospital in Weehawken.

Dr. Vincent J. Maida

The chief anesthesiologist of the Alexander Linn Hospital in Sussex died on April 11, 1973. He was Vincent J. Maida, M.D., a member of our Morris County Component Society. Dr. Maida was 65 years old at the time of his death. He was a 1936 graduate of Bellevue and had made anesthesiology his career. He also had been on the staff of the Memorial Hospital in Morristown and was a Fellow of the American College of Anesthesiologists.

Dr. Michael Pacicco

One of Hudson County's best-known family doctors, Michael Pacicco, M.D., died on May 7, 1973, at the age of 75. He was graduated in 1923 from the Medical School at the University of Naples (Italy) and came to this country in 1926. He established a general practice in Jersey City and has been active in the affairs of our Hudson County Medical Society. The MSNJ Golden Merit Award was granted posthumously to Dr. Pacicco at the 1973 Annual Meeting.

Dr. Lawrence E. Ulvestad

Lawrence E. Ulvestad, M.D., of East Orange, a well-known Essex County surgeon, died on May 14, 1973. A diplomate in surgery and a Fellow of the American College of Surgeons, Dr. Ulvestad was Attending Surgeon at the Orange Hospital Center, and had previously had a surgical appointment at Jersey City Medical Center. He was a 1932 alumnus of the Medical School at the University of Minnesota.

Dr. Peter J. Warter

Peter J. Warter, M.D., a member of our Mercer County Medical Society, who retired to Surf City (NJ) several years ago, died on April 11, 1973. A 1928 graduate of Hahnemann Medical College, he was an internist and had been affiliated with the Helene Fuld Hospital in Trenton where he had been chief of the arthritis section in their Department of Internal Medicine. He was a Fellow of the American Rheumatism Association. He was also a Fellow of the American College of Gastroenterology, but had devoted most of his professional career to rheumatology.

Dr. Harry J. White

Word has come in from Florida of the death there of Harry J. White, M.D., formerly of Metuchen, New Jersey. Born in 1898, he was 75 years old at the time of his death. He was a 1927 graduate of the Medical School of the University of Pennsylvania and his medical interest was in chest disease work. He had been on the staff of the Roosevelt Hospital in Metuchen, and he was a Fellow of the American College of Chest Physicians.

Dr. Daniel M. Winters

Word has just been received from Ireland of the death there of Daniel M. Winters, M.D., a member of our Monmouth County Medical Society. Born in 1920, Dr. Winters died on June 2, 1973. He was a resident of Red Bank and a 1950 graduate of the Medical School of Columbia University. Dr. Winters was an attending orthopedic surgeon at the Riverview Hospital in Red Bank. He was a diplomate in orthopedics and a Fellow of the American College of Surgeons.

BOOK REVIEWS

Renal Disease in Childhood. Edition 2. John A. James, M.D., St. Louis, Mosby, 1972. Pp. 377 Illustrated ($23.50)

Dr. James has written a brief, but comprehensive, book covering the field of pediatric renal disease. The kidneys in childhood are described anatomically and then physiologically. Clinical signs and symptoms are analyzed. Diagnostic technics, such as intravenous pyelography, cystography, and renal biopsy, are discussed. Included is a good description of embryologic and structural abnormalities of the kidney. Bibliographic references are extensive.

Kidney function and disease in the newborn period are presented, including descriptions of such items as the impaired concentrating mechanism of the renal medulla in the neo-natal period. A better understanding is gained of why the kidney cannot tolerate improper intravenous and formula feedings.

Common problems of urinary tract infections are discussed at some length, including the pathology, diagnostic criteria, and management. Recommendations are made regarding dosage and length of antibiotic therapy.

The third major topic is glomerulonephritis. The histologic criteria are analyzed and illustrated. Acute glomerulonephritis is distinguished from persistent glomerulonephritis and from the nephrotic syndrome. Criteria for steroid therapy and for cytotoxic drug treatment are given, along with the hazards of these forms of treatment.

Renal failure is treated concisely. It is refreshing to see how briefly and how simply dialysis and renal transplantation can be presented so that the uninitiated can gain a clear general understanding.

This book is an excellent survey and reference book for the entire field of pediatric renal disease. It deserves to be added to the shelves of pediatricians, urologists, and general practitioners who are particularly interested in kidney disease in childhood.

Robert H. Stackpole, M.D.

Licit and Illicit Drugs. Edward M. Brecher and the Editors of Consumer Reports. Mount Vernon, New York, Consumers Union, 1972. Pp. 623. (Paperback—$4)

Books about drugs continue to pour out of the presses. This is an especially comprehensive volume, even including glue sniffing. There is rich historical background material here. It is hard to realize that in the 19th century addicts participated in the life of the community and did not, as now, develop a subculture of their own. Brecher ascribes this deterioration of the addict to harsh law enforcement, arguing that severe penalties discourage convictions.

There is, says the author, no evidence that opiates ever cause brain damage. In general, he feels that the horror stories attached to opiates, LSD, and marijuana are exaggerated and that the really dangerous drugs are alcohol and tobacco. He points out the dismal recovery rates in all modern "rehabilitative" technics. His figures show that birth defects are no more common among children of LSD users than among women generally. Considering the widespread use of legal prescription drugs, the country is, he feels, focusing its anxiety and concern on a very small corner of the drug scene.

Brecher's recommendations include drop-in centers, crisis-intervention centers, street clinics, transcendental meditation experiences, and the banning of cigarette advertising and promotions. He has an almost messianic zeal in his condemnation of tobacco and in down-grading the hazards of marijuana and LSD. He is favorably impressed by the effectiveness of methadone as a treatment for opiate addiction. He also recommends the decriminalization of marijuana. In all, a vigorously written book that approaches its subject directly with no hemming or hawing.

Henry A. Davidson, M.D.

Newer Anticancer Drugs and Procedures. M. Fiorentino, Editor. Proceedings of a Seminar in Clinical Oncology, Padova, September 1971. Piccin Medical Books, Padova (Italy), 1971. Pp. 149. Illustrated. ($10)

This brief book of 150 pages is too well-bound, printed on too costly paper, and is generally not worth the effort expended in its organization for the information it portends to provide the reader. It is a digest, in somewhat abstract form, of the papers presented at a Seminar in Clinical Oncology in Padova, Italy, in September, 1971. Many presentations offer very little documentation for the conclusions reached. The caseload and case content of some of the individual investigators were certainly so minimal as to negate totally any conclusions reached. Some of the drugs, including BCNU, daunomycin, mithramycin, and actinomycin-D, have been extensively reviewed in the American and English literature and have been even published in standard texts, so that they certainly cannot be considered *new* anticancer drugs. Another drug considered in this book (Cytosine Arabinoside) was the subject of an extensive seminar at the National Institutes of Health in 1971. This produced far more solid conclusions than the brief experience mentioned in this publication.

Some of the other drugs listed in the book are totally unfamiliar to most oncologists in the United States and from the lack of efficacy indicated by the investigators, it is just as well that they have not been investigated here. There are a few pearls buried deep in the pages of rather superficial information, but these are scarcely worth the time that it takes to plough through the remainder of the book. I am afraid that I cannot recommend this book for any but the most esoteric oncologist, and even then with great reservations.

Melvin H. Freundlich, M.D.

Heritable Disorders of Connective Tissue. 4th Edition. Victor A. McKusick, M.D., St. Louis, Mosby, 1972. Pp. 878. Illustrations 1099. ($32.50)

This text demonstrates the rapid advances in our understanding of disorders of connective tissue. What twenty years ago took less than a page in a genetics text now can barely be contained in an eight hundred and fifty-page volume. For those of us out of medical school over ten years this is almost a foreign subject. As stated by the author, heritable diseases of

connective tissue are generalized defects involving primarily one element of connective tissue—collagen, elastic, or mucopolysaccharide—and transmissible in a simple Mendelian manner. This would include such disorders as Marfan Syndrome, Homocystinuria, Ehlers-Danlos Syndrome, and other genetic aberrations of the osseous skeleton. Practitioners or researchers desiring information on the above syndromes need look no further as the presentation here is detailed and complete. It is hard to beat 623 references on Marfan Syndrome!

It is interesting and good to learn that many of these syndromes are picked up only later in life when the patient complains of eye or cardiac symptoms.

For the pediatrician, internist, orthopedist, and geneticist this volume is most valuable. For any physician, it is worth scanning if only to know how little we know, and how we all must run just to fall behind a little.

Gerard F. Hansen, M.D.

Handbook of Medical Treatment. Milton J. Chatton, M.D., Editor. Los Altos, California, Lange Medical Publications, 1972. Pp. 648. (Softback—$6.50)

This handbook is just what it is called. It is small (7 x 4¼ inches in dimension), fitting easily into a jacket pocket or medical bag and weighs a mere 350 grams. The binding is secure, the paper strong, and the print highly legible. It provides quick, concise, thorough, and easily accessible information on therapy for practically any ailment that the practitioner may run into.

Included are sections on treatment for diseases of all the organ systems, infections, poisons, and nutritional problems. Each section begins with definitions of the problem. Then, there may be a few lines regarding diagnosis and prevention. The meat of the section follows: the various therapeutic measures available in a well-organized and codified fashion. Pharmacologic recommendations are brief but thorough and easy to understand.

I recommend this "Handbook" highly for all physicians. It is a valuable *vade mecum*.

Leo Lewin, M.D.

Thyroid Tumors, Lymphomas, Granulocytic Leukemia. M. Fiorentino, R. Vangelista, and E. Grigoletto, Editors. (Proceedings of the 2nd Padua Seminar on Clinical Oncology Padova, October 1972) Piccin Medical Books, Padova (Italy), 1972. Pp. 210. Illustrated ($13.60)

This may be classified as a book only because it has a series of chapters bound in a cover. A more correct description would be a collection of interesting papers bound together because of common origin from a single conference. There is no connecting thread that justifies the separate parts into a single text. The individual papers are well done, and obviously represent the carefully researched literature as well as personal experiences and valid conclusions of competent, or in some cases, outstanding scientists.

Thus we find excellent papers on the oncology of thyroid disease, myeloid leukemia and granulocytic leukemia, and finally, the lymphomas (especially Hodgkins), but there is no flow of continuity from one subject to another. Either there is no conceivable link between these separate topics or, if there is at least a theoretical one (which one suspects may be the case), the editors have simply failed to grasp the need to present it. All of the material presented can be found more easily elsewhere and I can not recommend this book to any physician building his own library (although this publication might be a handsome reference supplement in an institutional library with surplus funds and no other priorities).

A more specific criticism is the lack of an index although there are included approximately thirty-seven charts, twenty-six illustrations and twenty-nine diagrams.

Sydney B. Lewis, M.D.

Headaches: The Kinds and the Cures. Arthur S. Freese, D.D.S. Garden City, New York, Doubleday, 1973. Pp. 182. ($6.95)

This book is a disappointment. It was written by a dentist, presumably for lay people. It is poorly written. There are inaccuracies. On the positive side, the chapters and sub-headings are easily visible so that one could look for a particular point fairly easily. There are numerous quotations from many authorities on headache. There is much anecdotal information.

I would not recommend it to colleagues or patients.

Faith C. Walsh, M.D.

Handbook of Pediatrics. Tenth Edition. Henry K. Silver, M.D., C. Henry Kempe, M.D., and Henry B. Bruyn, M.D. Los Altos, California, Lange, 1973. Pp. 693 ($6.50)

This pocket-size book has enjoyed success in the pediatric field since first published in 1955. Every two years revisions have been made and material added to keep up with recent advances. This is more than a handbook, in the usual sense, insofar as it is made up of 693 small print pages. Even with the deletion of theoretical or experimental concepts of disease, the text might properly be regarded as a synopsis of pediatrics.

A handbook by definition is meant to be concise; thus one cannot be too critical of what has been deleted. However, certain material could have been revised further: examples being the still outmoded table on infant formulas and citation of gamma globulin as being without hazard. The subject of phototherapy in neonatal jaundice was too sketchy.

The bulk of the book is devoted to pediatric diseases with special sections on pediatric emergencies, poisons, procedures, drug dosage (with many trade names included), normal values, and so on.

Because of its brevity, this book should enjoy greatest success with students, house staff, and allied paramedical personel. The publishers were kind enough to have the outside title printed with an attractive phosporescent-type substance for easy access at night. Could the 1975 edition also include a small magnifying glass for us older practitioners? Still, hats off to the three Henrys for accomplishing a difficult task.

Frank C. Vanore, M.D.

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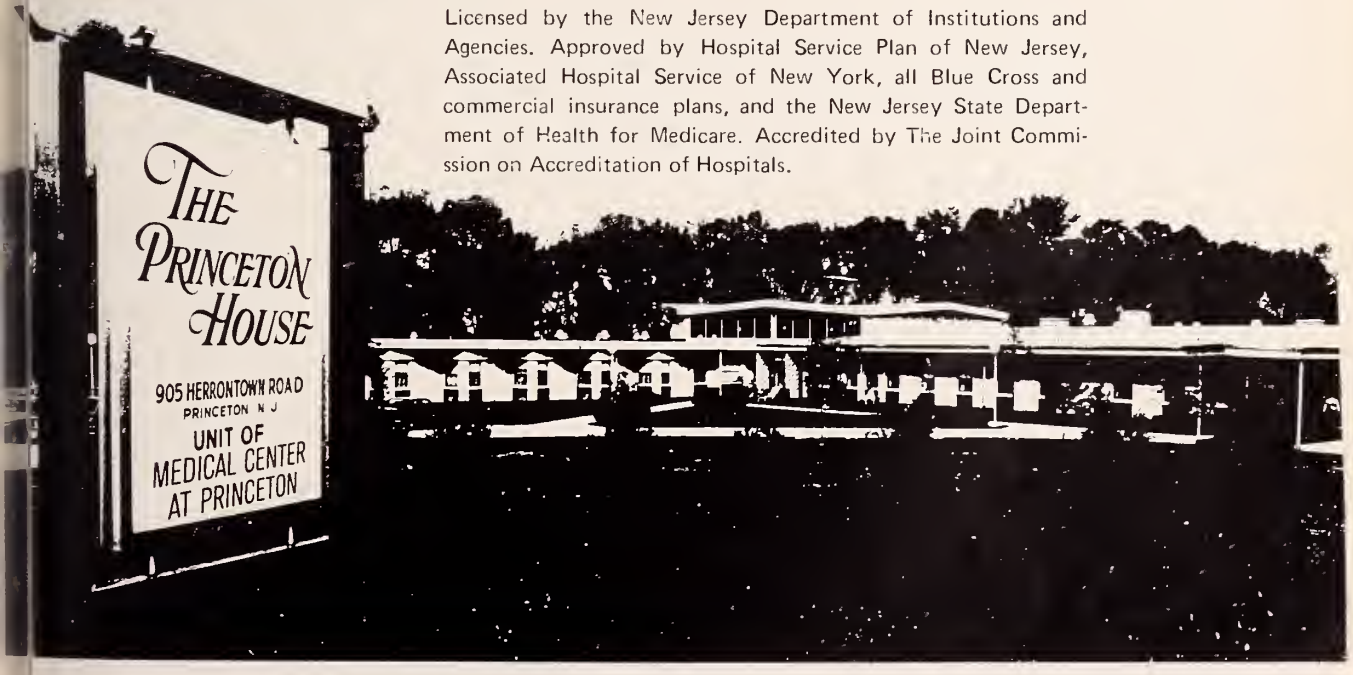
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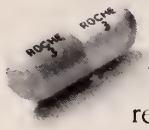
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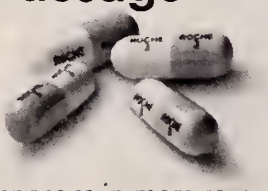
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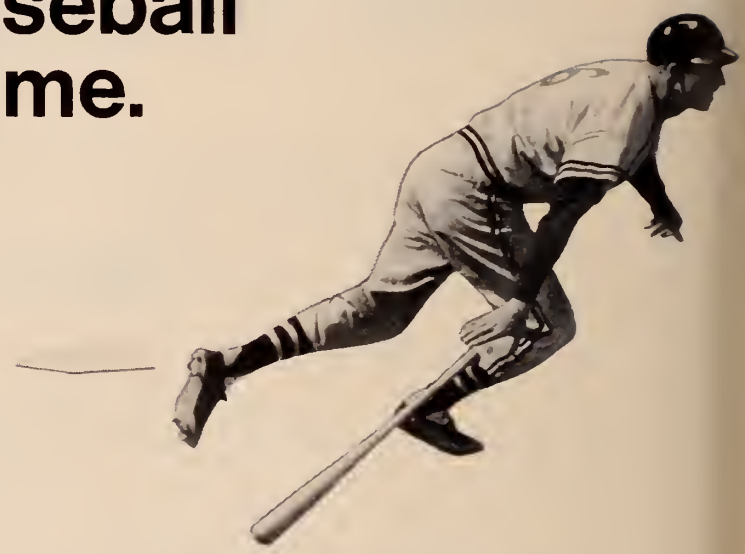
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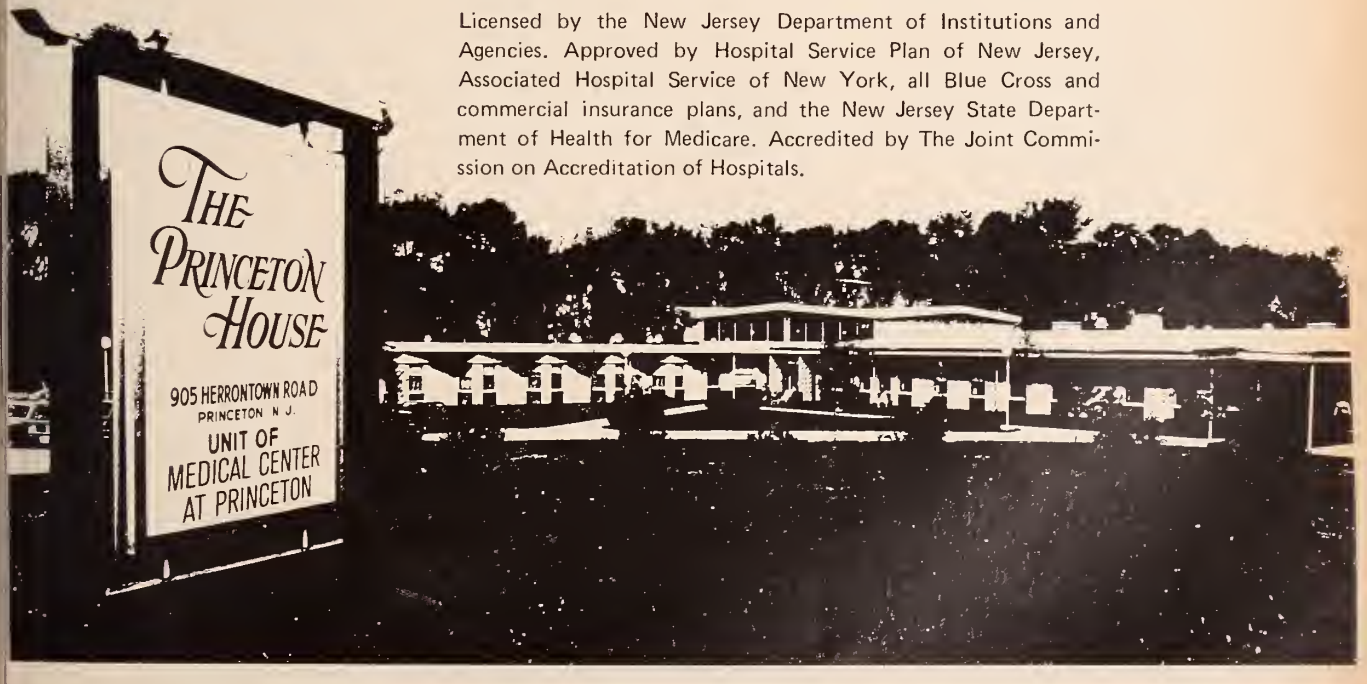
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Warnings: Age, weight, dosage, duration of therapy, presence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving) Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards Not recommended for use in persons under 15 years of age Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage. 15 mg may suffice in some patients *Elderly or debilitated patients:* 15 mg initially until response is determined

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl

ROCHE

ROCHE LABORATORIES
Div., Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

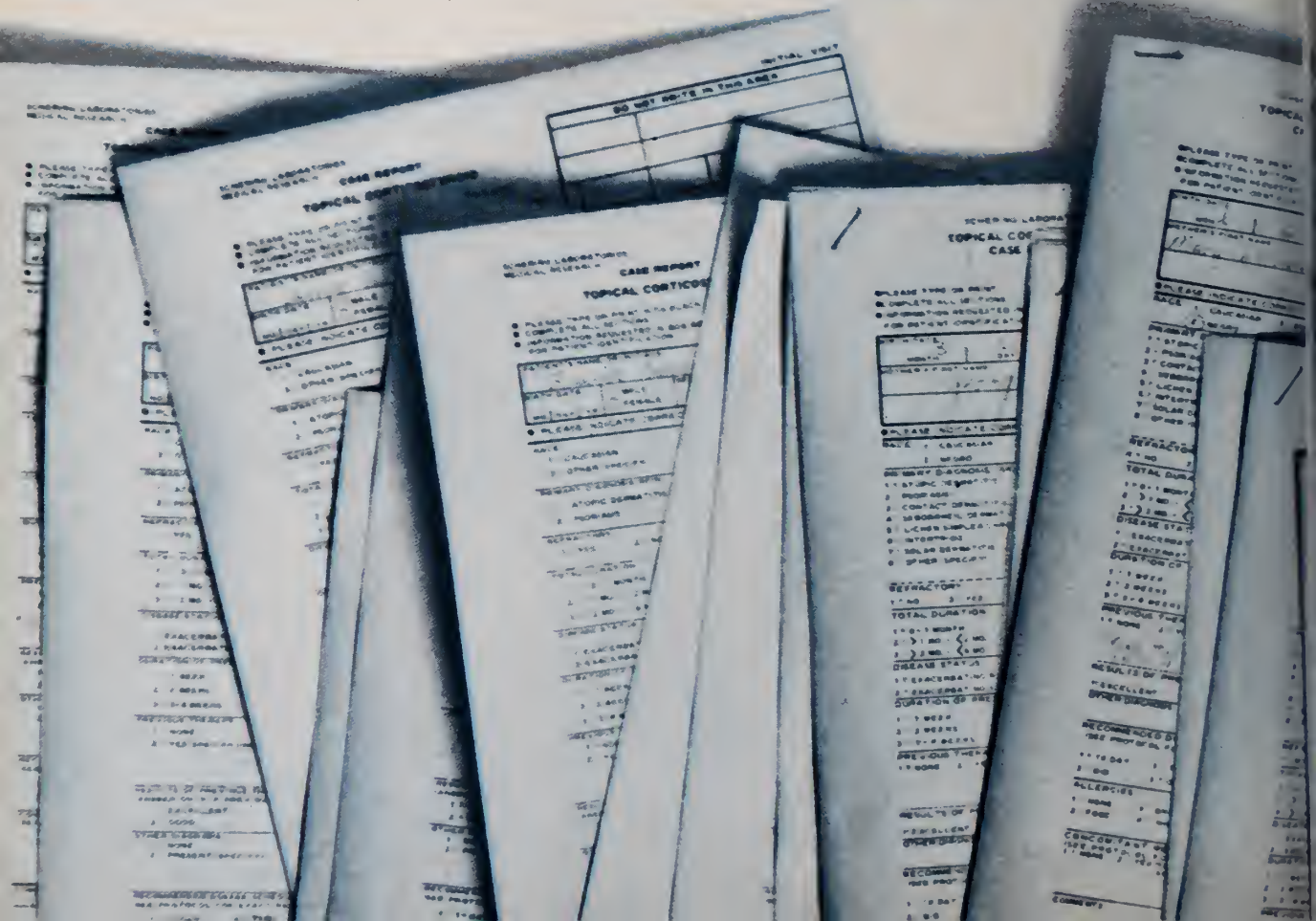
A topical steroid that has clinically succeeded

in study...after study...after study[1-6]

Excellent/good results

85% in psoriasis *(150 of 177 patients)*[1]

92% in atopic eczema *(231 of 251 patients)*[1]



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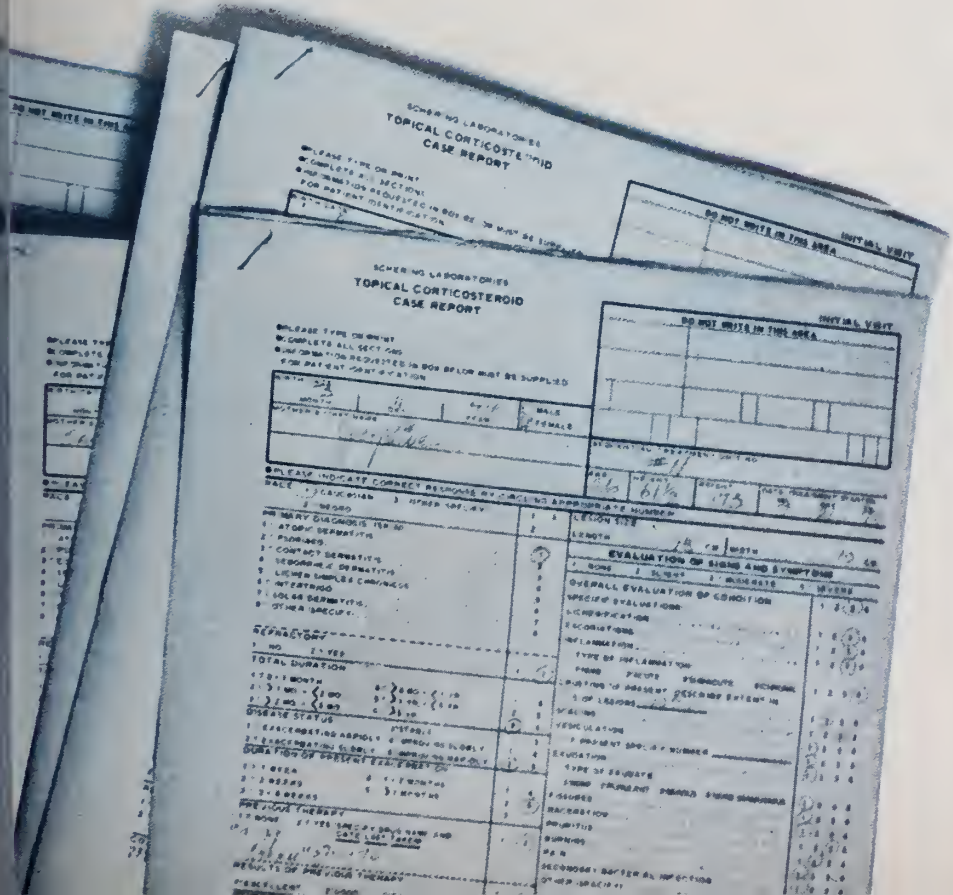
Valisone®

brand of

betamethasone valerate (0.1%) Cream/Ointment

Plus economy *B.i.d. dosage often found effective!*
Available in 5, 15, and 45 Gm. tubes.

96% in contact dermatitis
(81 of 84 patients)[1]



CLINICAL CONSIDERATIONS:

Description VALISONE products contain betamethasone valerate (9-fluoro-11β,17,21-trihydroxy-16β-methylpregna-1,4-diene-3,20-dione 17-valerate). Each gram of VALISONE Cream 0.1% contains 1.2 mg. betamethasone valerate (equivalent to 1.0 mg. betamethasone) in a soft, white, hydrophilic cream of water, mineral oil, petrolatum, polyethylene glycol 100 monocetyl ether, cetostearyl alcohol, monobasic sodium phosphate, and phosphoric acid; 4-chloro-m-cresol is present as a preservative. Eac gram of VALISONE Ointment 0.1% contains 1.2 mg. betamethasone valerate (equivalent to 1.0 mg. betamethasone) in an ointment base of liquid and white petrolatum, and hydrogenated lanolin. VALISONE Cream and Ointment contain no parabens.

Indications VALISONE Cream and Ointment are indicated for the relief of the inflammatory manifestations of corticosteroid-responsive dermatoses.

Contraindications VALISONE Cream and Ointment are contraindicated in vaccinia and varicella. Topical steroids are contraindicated ir those patients with a history of hypersensitivity to any of the components of the preparation.

Precautions If irritation develops with the use of VALISONE Cream or Ointment, treatment should be discontinued and appropriate therapy instituted. In the presence of an infection, the use of an appropriate antifungal or antibacterial agent should b instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled. If extensive areas are treate or if the occlusive technique is used, the possibility exists of increased systemic absorption the corticosteroid and suitable precautions shou be taken. Although topical steroids have not been reported to have an adverse effect on preg nancy, the safety of their use in pregnant femal has not been absolutely established. Therefore, they should not be used extensively in pregnan patients, in large amounts, or for prolonged periods of time. VALISONE Cream and Ointment are not for ophthalmic use.

Adverse Reactions The following local adverse reactions have been reported with topical corticosteroids: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneform eruptions, and hypopigmentation. T following may occur more frequently with occlusive dressings than without such therapy: maceration of the skin, secondary infection, skin atrophy, striae, and miliaria.

Dosage and Administration Apply a thin film of VALISONE Cream or Ointment to the affected skin areas one to three times a day. Clinical studies of VALISONE have indicated that dosage only once or twice a day is often feasible and effective. AUGUST 1972

For more complete details, consult Scher literature available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

References: *(1) Files of Headquarters Medical Research Division, Schering Corporation. (2) Carter, V. H., and Nooyin, R. O.: Curr. Therap. Res. 9:253, 1967. (3) Falk, M. S.: Cutis 2:788, 1966. (4) Goldblum, R. W.: Pennsylvania Med. 69:50, 1966. (5) Nierman, M. M.: J. Indiana M. A. 10:1184, 1966. (6) Zimmerman, E. H.: Arch. Dermat. 95:514, 1967.*

SLF

ROCHE announces new BACTRIM™

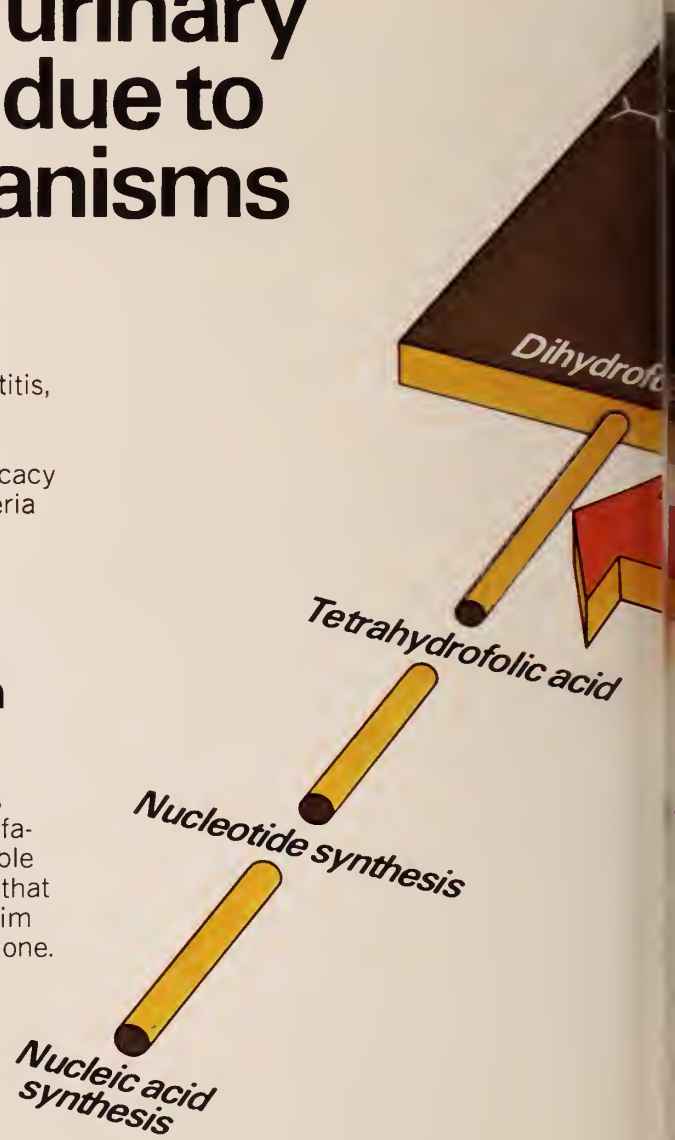
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

a new type of antibacterial for a two-pronged attack against chronic urinary tract infections due to susceptible organisms

Bactrim is highly effective in the treatment of these infections – primarily pyelonephritis, pyelitis and cystitis, when due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species). This efficacy is related to the unique mode of action against bacteria (see opposite page), an action that, in effect, makes Bactrim a new type of antibacterial.

Bactrim significantly superior to constituents in patients with obstructive complications

In the presence of obstructive uropathy, Bactrim has demonstrated efficacy which is superior to either sulfamethoxazole or trimethoprim alone against susceptible organisms. In addition, *in vitro** studies have shown that bacterial resistance develops more slowly with Bactrim than with either trimethoprim or sulfamethoxazole alone.



*Please note that clinical conclusions cannot be extrapolated from *in vitro* studies.



ROCHE

nterrupts life cycle of susceptible bacteria

nique mode of action interrupts the life cycle at two important points, thereby impeding e production of nucleic acids and proteins essential to these bacteria. These consecutive terruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing bstrates. By competitive replacement of these substrates, they inhibit further synthesis.

new **BACTRIM**™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

Before prescribing, please see complete product information on last page of advertisement.

Excellent clinical response in chronic urinary tract infections

A multiclinic, double-blind study* of response to a ten-day course of therapy in 471† patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. In patients with obstructive complications, 10th day response was 94.8% (of 97 patients) to Bactrim, 72.9% (of 85 patients) to trimethoprim and 58.5% (of 94 patients) to sulfamethoxazole.

Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after ten-day therapy with Bactrim, 68.4% of patients with chronic urinary tract infections maintained response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. In patients with obstruction, 70.8% of those on Bactrim maintained response for up to 42 consecutive days, compared with 49.4% on trimethoprim and 38.8% on sulfamethoxazole. The figures are particularly remarkable in cases with urinary obstruction—cases regarded as being notoriously difficult to treat.

To date, low incidence of significant side effects

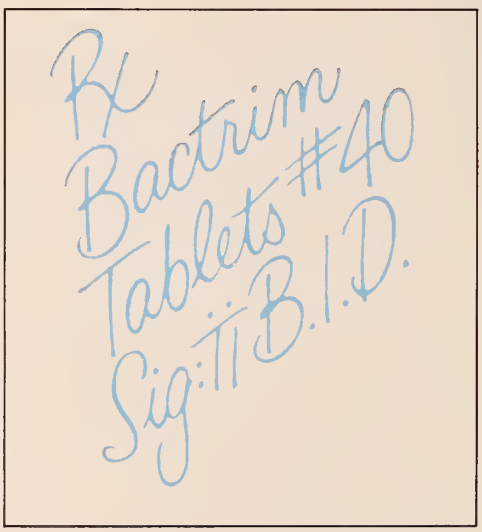
Although Bactrim demonstrated impressive clinical results, it is important to note that the incidence of clinically significant adverse effects was low, mainly nausea and/or vomiting, rash, leukopenia, SGOT increase and creatinine increase.

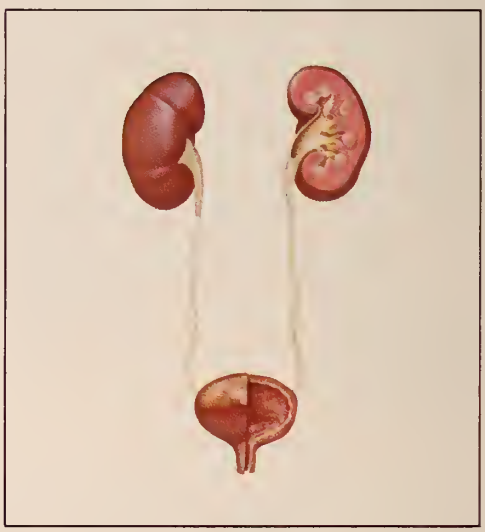
Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency and to those with severe allergy or bronchial asthma. Adequate fluid intake must be maintained. Complete blood counts, urinalyses with careful microscopic examination, and renal function tests should be performed during therapy.

Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.

Usual adult dosage: two tablets every twelve hours for 10 to 14 days; no loading dose required.

* Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110
† 4 patients not available for evaluation at day 10.





new **BACTRIM**™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, N J 07110

Before prescribing, please consult complete product information on facing page.

Complete Product Information:

Description: Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is N^1-(5-methyl-3-isoxazolyl) sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

Actions: *Microbiology:* Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with *para*-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

In vitro studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

In vitro serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms
(MIC—mcg/ml)

Bacteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20) TMP	TMP/SMX (1:20) SMX
Escherichia coli	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
Proteus spp. indole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
Proteus mirabilis	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
Klebsiella-Enterobacter	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

Human Pharmacology: Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than are the concentrations in the blood. When administered together as in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species).

Important note: **Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.**

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

Warnings: Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

Precautions: Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Reactions: For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

Miscellaneous reactions: Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration: Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

How Supplied: Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

Reproduction Studies: In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

BACTRIM™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

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The JOURNAL regrets to report the death of our beloved Editor, Henry A. Davidson, M.D. on August 22, 1973. Editorial comment and obituary will appear in the October issue.

EDITORIALS

Team, Team, Team!

Group work and team work! These are the catchwords today. We spend hours in committees and conferences. We urge our colleagues to work on our team. We suggest that the group process is an important part of corrective emotional living. We repeat ritualistically that two heads are better than one, that there is strength in union, and that when it comes to creative thinking, there is nothing like the rub of mind on mind. Ah, there's the rub. Committees are slow to make decisions. Indeed, when a crisp decision comes swiftly out of a committee room, it is generally because one person in the room is being very bossy. When members of the group are at loggerheads, it is usually the more mature, the less excited, the wiser person who yields. The stubborn member of the group with the thoughtless, unimaginative, inflexible position and the loud voice is more likely to get his way. Thus, in a real sense, the committee, conference, or staff meeting may lead to a triumph of mediocrity. Too often "consensus" is the victory of childish shouting over mature judgment.

We who have to deal with the emotionally disturbed have learned to depend on subtle clues, on nuances that are sensed through intuitive antennae. Committees have no such receptors. A staff conference can certainly reach an "average" opinion, but the average is seldom really good enough. Compromise is too often on a plan of action that no one can accept with enthusiasm. The average between plus two and minus two is usually zero.

In many areas of the business world, this kind of decision-making process often works well. But such is the uniqueness of an individual's problems that the practice of medicine, the last bastion of individualism, must remain an area beyond reach of the computer, the consensus of the committee.

The Temptation to Advertise

When the senior practitioners among us were just starting in, the medical societies had a rather rigid, dogmatic ban on anything that might be construed as advertising. If a physician's name appeared in the newspapers, even in the context of a social note, a public speech, or advertising for a lost dog, this publicity was assumed to be self-aggrandizement. As late as its 1955 edition, the AMA's *Principles of Medical Ethics* had a long section entitled "Advertising" which included, "Among unethical practices are included the not always obvious devices of inspiring newspaper or magazine comments concerning cases in which the physician or institution has been concerned." However the current (1972) *Principles* simply omit any reference to advertising or self-aggrandizement.

This is, perhaps, a belated but realistic acknowledgment of the situation today. If you have under your care a man or woman of considerable prominence, you may be besieged by reporters who will publish the name of the treating physician and there isn't anything you can do about it. Note that the 1955 canons of ethics specifically condemn comments about the institution as well as the individual practitioner. Today hospitals and medical centers often have public relations departments which strive to get the institution's name in the papers. The public has a right to know, has a deep interest in medicine and surgery, and wants to keep apprised of medical and surgical progress. At one time, the practice was to ascribe information to "a spokesman for the County Medical Society" without naming him. This is no longer acceptable to the press which puts "who" first in the traditional triad of "who, what, and where?" Furthermore, with current concern about the "image" of the physician, one can defend giving publicity to the successes of individual practitioners. Perhaps some of us may offer a requiem on the disappearance of a quaintly old-fashioned ethical principle, but this is one of the facts of life of 1973.

Running and the Decay of Conversation

Conversation is rapidly becoming extinct. Man's verbal instinct is to fight or preach. Argument is our forte, not dialogue. And that failing, we go into a sermon. "Every time I start to talk to my children," a friend told me, "it turns into a lecture." This is not only not conversational, it is nonsensical. "The psychologist," writes C. G. Jung, "has come to see that nothing is achieved by telling, persuading, admonishing, giving good advice."

Unfortunately we find most other kinds of talk difficult. I recall hearing Steve Allen, the glibbest interviewer of all time, say one day that he was in no hurry to leave the studio because, "When I get home tonight I have to ad lib a whole hour with my mother-in-law."

So what passes for dialogue or communication is either the verbal ping-pong of the TV talk show, the small talk of the passing-in-corridor variety, or the chatter indulged in at innumerable cocktail parties. This monotonous hum is so readily recognizable that Bob Considine's son watching one night from the upstairs landing asked his father, "Haven't we had this party before?"

At least, however, these parties allow the use of the vocal cords and protect them from atrophy. This last is a present danger to the average U.S. household where the TV is on an estimated six hours a day—placing the average American family well on the way to becoming as mute as giraffes.

Running has none of these limitations or hazards. The second wind, which opens the runner to unknown and unsuspected physiological delights, also reveals unexpected insights into his psyche and his inner self, and at the same time makes the conversational juices flow. I have found this state of perspiration and euphoria can perform minor miracles, can eliminate those feelings of guilt which lead to sarcasm and bitterness, can rid me of the righteousness that produces sermons, and can even dispel the selfconsciousness that limits me to talk about the weather and the state of my partner's health. Running frees me from the monosyllabic inanities of my usual tongue-tied state. It liberates me from the polysyllabic jargon of my profession and removes me from the kind of talk which aims at concealing rather than revealing what is in my heart and what I mean to do and be.

A midwestern psychiatrist once wrote me about a withdrawn patient who refused to talk to anyone about what was troubling her. It was only when they started to take runs around the institution's grounds that she suddenly began to reveal her basic problems in great detail.

I'm at a loss to know why this happens to runners and those who run with us, but I surmise it has something to do with our deepest instincts about movement. That, at any rate, is the suggestion of Dr. Thomas Harris who wrote the best seller, *I'm OK—You're OK*. Harris divides each of us into three parts: Parent (which is life as it is taught by the rule book) Child (which is life as it is felt or wished) and Adult (which is life as we figure it out for ourselves.) The first Adult act we do, says Harris, is locomotion. The Adult in us begins when we take our first step—our first walk to think things over. From then on we have the recording in our brain that movement is good, that it helps us to see more clearly what our problem is.

Harris is probably right. Walk to clear your mind. Run to clear your mind. If you do, you can see yourself, however imperfect, as a unique unrepeatable adult. If you do, you can reach out for relationships based on accepted imperfections and weaknesses which only adults acknowledge. I exaggerate, of course. Running is simply a superior way to lower your cholesterol, improve your muscle tone, slim down your waistline, and prevent heart disease. It has nothing to do with finding the inner man, Jung's "undiscovered self"—Nothing to do with becoming an adult. Or does it?

George Sheehan, M.D.

ORIGINAL ARTICLES

Offered here are some suggestions about the cause and handling of the generation gap.

Nihilism And Despair, Rebirth And Repair*

A Psychoanalytic View of the Adolescent Crisis

Ira L. Mintz, M.D./Englewood

The adolescent years have long been recognized as years of storm and torment. What has plagued parents, educators, and teenagers themselves in recent years, is that this period has become even more frustrating and tumultuous, more rebellious, more violent, and more hedonistic. Because of the rapid changes in our culture, the adolescent today is faced with a whirling melange of problems unsurpassed in recent memory.

World-wide television provides violent and rebellious peer groups with which to identify. The availability of drugs encourages the illusion of an immediate solution for complicated problems, an escape into fantasy, self-destructive acting-out behavior, and a passive helplessness rather than an active mastery of situations. The birth control pill can allow unfettered sexual behavior without the worry of pregnancy, but with the return of venereal disease.

In order to evaluate more accurately the interplay between the adolescent state and the bewildering environment in which the adolescent finds himself, a brief summary of the nature of the adolescent process is in order. The age of adolescence, from about twelve to twenty, follows a period of latency or quiescence (age six to eleven) in which the child completes a period of intellectual, emotional, and physical growth and development, essentially unhindered by violent psychologic or physiologic changes.

The adolescent stage, however, erupts with a marked upsurge in sexual and aggressive drives, concomitant with and abetted by attendant physiologic changes, and tends to overwhelm the previous state of equilibrium.[1] Aggressive feelings emerge with attitudes of unruliness, rebellion, and antisocial behavior, and oscillate with previous attitudes of neatness, modesty, and consideration. Sexual impulses, fantasies, and often behavior, become overpowering and preoccupying and alternate with feelings of ascetisicm, mysticism, and sexual abstinence. These drives exist in all adolescents, but are handled in different ways. The need to devalue the parents and their presumed omnipotence is a necessary step in adolescent independence and maturation, but it can suffer from all the excesses of adolescent exuberance. Thus, it may temporarily include all of their standards, values, and interests, and in marked instances, can extend into conflicts with all authority with resulting antisocial behavior.[2] In the name of independence, the adolescent must renounce parental standards, morals, and identifications. Yet he is expected to step forward with increasing independence and responsibility, with little past successful behavior or sense of cohesiveness to support him. He feels obligated to devalue parental standards, yet to have an appropriate set of standards of his own. The persistence of an unconscious need for authority figures, however, is satisfied by

*Read before Section on Psychiatry, 207th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 13, 1973. Dr. Mintz is a member of the faculty of the Columbia University Psychoanalytic Clinic and the New Jersey Medical School, CMDNJ.

the peer group, which stands for the parents, and, therefore, accounts for the tremendous influence it is able to wield. The adolescent must renounce his early oedipal sexual feelings, but must not fully repress these drives for expression. so that they may ultimately go on to sexual freedom.[3] What is evident, therefore, is the simultaneous presence of a number of intense conflicts over aggressiveness, sexuality, independence, a sense of morality, ethics, and life goals. First one conflict moves to center stage, and before the drama is completed, it is replaced by another. In addition, what one sees, often in alternating fashion, is the eruption of aggressive feelings, only to be followed by an attempt to defend against the emergence of this aggression. Hostile behavior, therefore, may oscillate with meekness. Independent attitudes may alternate with infantile dependent ones. Sexual interests and preoccupation interchange with sexual disinterest and apathy. These attitudes reflect an attempt to deal with conflict, and one is able to view both sides at different points in time. Conflict is the hallmark of adolescence, and inconsistency is its handmaiden.[4] This is normal and to be expected.

The adolescent is at times a most intelligent, sensitive, and introspective individual, tuned in to an awareness of his own inner feelings, cognizant of the social needs of a community, with an altruistic sense of justice, and capable of an astounding intellectual achievement. Foremost musicians, mathematicians, and chessplayers attest to this creative propensity. In quick succession, the reversal of this behavior is often evident. The adolescent can react with explosive anger and brutal violence, with an infantile petulance, with obtuse insensitivity to the feelings of others, with impulsive and poor judgment, and with totally unrealistic, immature requests and behavior. What parents, educators, and administrators find difficult to cope with is the bewildering series of changing attitudes, behavior, and requests made upon them. They anticipate consistency and respond as if it exists, when in fact what is truly consistent is the inconsistency.

The task of the adolescent period, then, is to maintain conditions of flexible ego growth and development. The aim is to create a sense of identity, facilitated by independent growth, control of sexual and aggressive feelings, the consolidation of areas of learning, the handling of important decisions in life, and the development of appropriate moral and ethical standards.[5]

All this leads us to conclude that the adolescent, as well as the adult, functions on both a conscious and on an unconscious level. What may be vigorously pursued consciously, she may unconsciously want someone to protect her against doing.

A 15-year-old girl had a big fight with her mother over her demands for freedom and independence. When these requests were not met, she threatened to run away from home. She then added, in a hopeful and momentarily insightful manner. "You'll send the police after me, won't you?" Her conscious impulses for unrealistic degrees of independence were almost simultaneously countered by her need to remain at home. Unable to contain her impulses, she was requesting her parents to aid her in staying home with the help of the police.

An 18-year-old boy going to a local college was in the midst of working out his feelings of independence from his family. Most of the time he fought with them and could not wait to leave home. He remained in the area to continue his analysis. One day he decided to spend the summer in Europe with his friend. That night he had the following dream:

"I'm back in summer camp. I'm 18 but I feel like I'm little. The counselor is telling me what to do and I resent it."

His associations followed the manifest content of the dream. "I'm thinking of going away to Europe so I dream of being in camp. Part of me wants to be little; to be told what to do though I resent it. The counselor is also someone who advises you . . . thoughts about how I'll feel away from home . . . how will I behave . . . so I get a counselor who will be with me all summer."

Clearly his desire for independence is accompanied by regressive needs to be advised and cared for both in the activities during the summer and in the transference.

How do the recent marked changes in our society affect the adolescent's ability to cope with life, and to resolve those problems necessary for his becoming a mature, stable adult? These major changes have to do with (1) the widespread violence, (2) the excessive permissiveness by parents and educators, (3) the excessive sexual stimulation, (4) some of the

cynical, hedonistic attitudes of the art culture.

All human beings are forced to cope with problems of violence. The source of the violence may be external or internal. We fear violent assault from other people: muggers, robbers, during war, and so on. The fear of the external damage, while frightening, is clearly perceived. What is less clearly recognized, is the fear of erupting violence from within. Those of us who appear excessively meek and obsequious, frequently are attempting to cope with violent inner impulses by unconsciously denying their existence, appearing mild-mannered, and attempting to prove to all, including ourselves, that no one need fear us. Conversely, people with strong aggressive feelings and poor control over them, are constantly plagued with the fear of loss of control over the aggression, and a fear of running amuck. If people feel better when additional controls are provided, and violence is, therefore, minimized, the converse is also true. Where there is a great deal of violence present, certain persons have greater difficulty in controlling their own violent impulses. The other person's violent behavior undermines one's own self-control, because one identifies with the perpetrator of the violence. The police are very well aware of this, since a violent crime is often followed by a wave of similar crimes, as well as by false confessions. A very sick, aggressive child became panic-stricken after he found out that a six-year-old boy had stabbed both his parents to death while they slept. He was clearly fearful of losing control, and doing the same thing.

The adolescent who has to contend with a tremendous increase in growth and strength and also an increase in aggressive feelings, is frequently fearful that he cannot control himself. Those adolescents who are less stable, and who are preoccupied with violent fantasies, have even more difficulty in containing the aggression. Violent behavior in the streets, in the schools, and on the campuses, makes it more difficult for these people to behave normally. An episode of violence on one campus undermines the self-control of the less stable students and they behave in similar fashion. Violence leaps from one campus to another. Television viewing of violent unrest graphically portrays the experience, and consequently adds to the impulse to act out the violence in these people. A reasonable, firm college administration would support the means for the self-control within these students. Where the administration responds passively, vacillates, or gives in to unreasonable demands, this serves to augment the aggressive impulses.

The conscience that develops in childhood is modified and remodeled in adolescence, depending upon the child's growth and development, the current life experience, and the attitudes of the parents. The adolescent identifies with the parental standards and behavior, and is encouraged to control his impulses by firmness and consistency on the part of the parent. When this firmness is lacking, the adolescent often is left to the mercy of his own "uncontrollable" impulses. Carried away by these impulses, the adolescent will often impulsively request what he unconsciously wants his parents to deny him. How confusing it is to the adolescent when instead of being able ultimately to identify with the adult's standards, dress, and ethics, the adult identifies with his. When adults attempt to bridge the generation gap by behaving like teen-agers, instead of serving as mature models for them, the rift is widened and not narrowed. If parents and educators permit the child to do whatever he chooses and are indulgent and over-permissive, the child gets no opportunity to absorb aspects of self-control and self-discipline into his character structure. He does not learn to postpone gratification, to tolerate reasonable levels of frustration, to work, and to do what is necessary in place of what is pleasurable. This results in his feeling overwhelmed by the frustration, conflicts, and reality requirements of daily living.

These attitudes develop very early in the child. One mother, requesting a consultation for a wild, unruly child of six, who was disrupting his class in school, first reported the rebellious, destructive behavior at age three.

When confronted by his destructiveness, she would helplessly go through the motions of telling him to stop, fully knowing that she did not expect him to, and unconsciously communicating that idea to him. Another time she would threaten this three-year-old with the police if he did not behave, clearly abrogating what was left of her authority and assigning it elsewhere.

When a school does not set reasonable limits, it undermines the child's ability to work. Working in school is not synonymous with play and with pleasure. Aspects of school work can be exciting, stimulating, rewarding and gratifying, but they are still not the same as pure pleasure. Work requires concentration, study, attention, thinking, evaluating, selecting, rejecting, synthesizing, organizing, and the like. It is an error to equate learning in school with play out of school, and an attempt to fuse one with the other confuses and misleads the student. A corollary for learning is the need for a setting of peace and tranquility, where the student is able to think and to concentrate. Where there is violence, unrest, and turmoil in the school setting, the student has greater difficulty in learning. Where there is violence, conflict, and anxiety existing within the student, he also has great difficulty in understanding. Whether the turmoil is external or internal, it interferes with the mental requirements for learning.

The third factor to be considered is the excessive sexual stimulation that has swept our culture. Here, too, the adolescent person has great difficulty in controlling erupting sexual urges. Where the adolescent is unable to masturbate to discharge what are often perceived as overwhelming sexual impulses, he often feels driven to premature sexual intercourse. A number of adolescent girls who were conflicted about masturbation, reported frequent and promiscuous sexual behavior. Those girls who worked out their conflicts about masturbation and were subsequently able to masturbate without excessive guilt, stopped the sexual intercourse. They reported feeling less sexually driven, and more able to regulate the nature and level of their relationship with the boy. If these adolescents have obvious difficulty in controlling their normal sexual urges, to overwhelm them with titillating experiences in plays, movies, and dormitories clearly increases their difficulty in coping with their own inner feelings. One college student, home on vacation, reported the constant turmoil she experienced at hearing the sexual activity through the wall in the next room. Another felt panicky at all the sexual exposure, and was unable to concentrate and study until she was able to move to an all-girl dormitory. Many students feel inside that they are not ready for a mature sexual relationship, but feel overwhelmed by the pressures for it. There is no place to hide, no curfew behind which to take refuge, no college rule that can safely be invoked, without the loss of face. There is blatant sexual exposure with no obvious way out. Some students find a way: they drop out, often without fully knowing that their poor grades in considerable part reflect this sexual conflict, and their return home provides their refuge.

What we constantly fail to recognize is the ambivalence of the adolescent. That while the need for independence and sexual freedom is widely trumpeted outside, the small, quiet voice inside desperately pleads for control and protection. When the parents clearly perceive that the child is doing the wrong thing, it is necessary gently, firmly, and consistently to interfere.

For example, an "enlightened" mother fears that she is unable to exercise any influence over her fifteen year-old daughter's sexual activity. She therefore "ensures the daughter's safety" by bringing her to the gynecologist, who provides her with birth control pills. Both the gynecologist and the parent have tacitly approved of the girl's having sexual intercourse. The girl does not use the pills, however, and instead asks a boy friend if she should start on them, hoping to be told to refrain. While protesting her great sexual freedom to her mother, (who then became frightened, and provided her with the pill), the girl clearly does not wish to use it, nor to have intercourse. She should have been told that she is too young to get that involved and that her parents do not want her to.

Another girl would make all kinds of unrealistic demands upon her parents, including going to parties without any parents at home to supervise, and wanting to visit a dangerous park at night to hear a rock concert. When they refused, she exploded with yelling and screaming. They remained adamant, however.

Next day she was quiet and friendly. Her need was to demand consciously what she unconsciously was afraid of. She was grateful for their helping her to stay out of trouble.

These obvious inconsistencies in adolescent thinking and behavior are not a sign of pure immaturity. Nor does the advocating of firmness on the part of the parent mean to suggest that the adolescent's request should not be taken seriously. What it does mean is that the process of adolescent growth and development is exceedingly complex: that it is characterized by progression and regression, by ambivalent attitudes about all major issues, by a constant changing and shifting of values, interests, and goals, and that the inconsistency noted is a necessary aspect of this stage of growth and maturation. As adolescence draws to a close, the thinking and behavior becomes more constant, reflective and mature.

One particularly insightful young woman looked back upon her own rebellion, drug usage, and sexual behavior. She commented upon the sense of disappointment that she had experienced. Ever since she was a child, she had looked forward to adolescence: to the dances, the parties, the dressing up, the dating. She felt cheated. What she got instead, was living in dirty dungarees, smoking pot, feeling alienated, and thinking that she was cool. She reflected further and felt that some of the rampant sexuality was partially responsible: that girls dress in dungarees in order to avoid arousing sexuality in boys. The unisex type of dress was an attempt by both boys and girls to minimize and to deny sexual differences in order to cope with excessive sexual anxiety. And finally, that the long-haired boys who looked like girls, were also attempting to deal with their own premature sexual pressures, by denying sexual differences.

A recent experiment at the University of Michigan (*New York Times,* February 28, 1972) reported men and women students rooming together on a non-sexual and "platonic" basis. Here again is an attempt at denying any sexual difference: that boys and girls are alike, that mature men and women can walk about nude without arousing sexual feelings in each other. Under the overt guise of increased freedom and sexuality we see instead a regressive infantile denial of sexual feelings, and replacement by a non-sexual, ascetic behavior.

A similar experience is evident in the spread of certain cults. This is illustrated by the Hari Krishnas, an incense-using religious group, worshipping the Lord Krishna. Of particular note is the "thou shalt not" aspect of their religion. One group of men shave their heads, wear dog collars of beads and saffron robes. They are celibate. Couples, by contrast, are permitted intercourse, but it is limited to once a month. They must pray for two hours prior to copulation, however. Women are forbidden to have intercourse after the age of 30. Followers are also forbidden to benefit by the destruction of animal life. Consequently, no food or clothing derived from animals is permitted. All drugs are forbidden, including the use of Coca-Cola and tea.

One wonders what would attract young people to such a restrictive life. The answer lies in part, I think, in the fact that the devotees of Krishna have found, under the guise of a religious commitment, a strict, ascetic society with a built-in set of controls and procedures for behavior. A number of them, before entering the Hari Krishnas, behaved completely out of control. They were revolutionaries, users of pills, cocaine, and heroin, and were promiscuous in their behavior. Current controls in our society were not sufficient, and a more drastic requirement was necessary.

The fourth factor is the response to the art culture. The productions of the "liberated" art culture have served further to aggravate these conflicts. Brutally raw and violent films, plays, and television intensify latent aggressive feelings. The same problem exists with luridly provocative sexuality. Here, too, sexual impulses are stimulated and heightened.

Avant-garde artists have proclaimed in song, book, and film a new morality with which the youth of the country may identify. It consists of the glorification of violence, the admiration of the clever criminal, the "cool" use of drugs, the advocacy of impulsive and sadomasochistic sexual behavior, and a contemptuous view of established values, ethics, and morality.

The adolescent, often in the throes of ejecting previous values and standards, is faced with

an inner emptiness of these values and standards, and experiences considerable anxiety and lack of identity as a consequence. There is, therefore, a psychologic need to fill this vacuum in value systems in order to regain some feeling of identity and to diminish anxiety. This makes him particularly vulnerable to the impulsive and non-discriminatory introjection of whatever values and attitudes exist within his milieu. This is what often accounts for the sudden appearance of all kinds of cults, fads, strange interests, and on occasion, almost bizarre attitudes. The larger the inner lacunae, the greater the anxiety and confusion over the absent sense of self, and consequently, the more impulsive and non-judgmental will be the identifications. When the admired artist or film protagonists engage in violent, sexual, cynical or hedonistic behavior, the urge to identify with them is correspondingly great. Concomitantly, those aspects of conscience and judgment which would serve to mitigate against this behavior have been weakened by the changing moral and ethical climate which devalues and derogates the Protestant work ethic.

Our culture cannot eliminate the crises of adolescence because they are in part intrapsychic, and in part require confrontations with the parents, and with aspects of society, in order to achieve maturity. But the culture can play a role in determining what choices are available in the solutions of these problems. Our society encourages destructive acting out and rebellious, anti-social behavior. It provides delinquent, cynical, drug-oriented, hedonistic models for the adolescent to identify with.

In the past typical adolescent conflicts would be responded to by depression and similar symptoms, and less acting out. This was advantageous because the child suffered, and through its suffering realized that something was wrong. This encouraged attempts at introspective searching for solutions, alone or with some kind of help. This is more difficult today, because our culture is less "intellectual," is action-oriented, non-introspective, and demands immediate gratification for its needs. Therefore, today's acting-out adolescent in great part avoids intra-psychic conflict and anxiety, and externalizes the problem onto society. Guilt-ridden adults and institutions who are quick to accept the barbs and tirades of adolescent externalizations, tend to provide the stamp of reality upon many adolescent projections.

Summary

To summarize, the process of adolescent growth and development is a ubiquituously difficult experience. Inner turmoil, changing values, interests and attitudes, difficulty in coping with erupting sexual and aggressive drives, a need to defy the established order, a disturbed sense of identity, all contribute to a particular inner vulnerability, and fragility of the ego. When external pressures are added, in a culture which is suffused with standards and behavior which are essentially regressive and disruptive, the tasks of adolescence are further compromised and impaired.

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39 Park Place

Malignant mesotheliomas have high neoplastic qualities, but, if treated early, life expectancy may be improved considerably. Here is a case report.

Mesothelioma as Primary Tumor of the Peritoneum*

A Case Report

Victor D'Ambrosio, M.D./Murray Hill

Mesothelioma is the only primary tumor of the peritoneum. This extremely rare tumor may be benign or malignant. The lesions can be localized or diffuse and can manifest themselves in plaque-like and nodular forms. From time to time, authors have written of mesotheliomas originating from the ovary, broad ligament, epididymis, tunica vaginalis, scrotum, spleen, kidneys, and adrenals. Upon an extensive review of the literature and the pathology of these tumors, we conceive the idea that actually these tumors represent differentiation of the same process and the mesothelioma is the only primary neoplasm of the peritoneum.

Mesothelioma originates from the cells of the mesothelium, which derives from the mesoderm lining of the primitive body cavity. In the adult it becomes the epithelium covering the serous membranes.

The microscopic appearance of this neoplasm can vary from the papillary form to the fibrous, the acinar or even the squamous cell tumor. When one considers the information collected from our case, on the base of clinical course and the histopathologic evidence, there seems to be little doubt that the mesothelioma can assume a benign form at the early stages of its development and that it gradually progresses to the highly undifferentiated form of the malignant type. (See figure 1)

Mesothelioma appears to be more common in the male than in the female and it is more frequent between the ages of 40 and 70. The youngest patient reported and the oldest were of the ages of 2 and 80 (Bibacchi[6]).

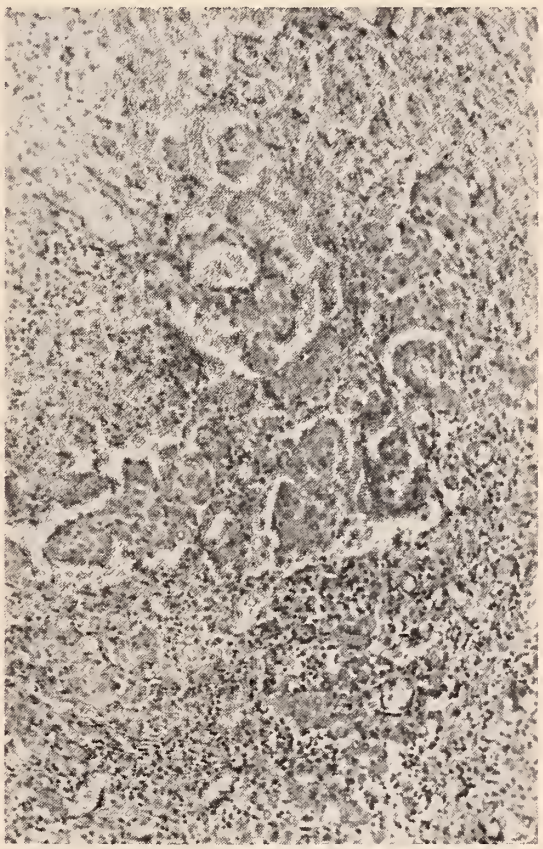


Figure 1—Microhistology showing marked granulomatous proliferation, which at the time of surgery exhibited all the characteristics of a benign form.

Mesothelioma can manifest itself by a swelling of the abdomen, due to ascitic fluid accumulation and cramps of minor degree. Rarely, these patients have evidence of partial intestinal obstruction.

*From the Surgical Department at Overlook Hospital, Summit.

Our patient had a bilateral inguinal hernia with some discomfort localized to both inguinal regions. The abdomen was of normal size, no fluid or masses were detected on physical examination.

A 62-year old male was referred for repair of a bilateral inguinal hernia. Up to the time of admission, he worked very actively as a farmer, and had no other complaints. On admission to Overlook Hospital in February, 1967, chest x-rays, flat plate of the abdomen, blood count, urinalysis, electrocardiogram and SMA_{12} were all reported within normal limits.

On March I, 1967, the repair of the left inguinal hernia was carried out. Upon isolating and opening the indirect hernial sac, an irregular fragment of hemorrhagic and fibromembranous tissue, measuring 7.5 by I cm., was found. This was removed, the hernia sac was dissected and highly ligated with 00 silk suture ligature and the hernia was repaired according to the Bassini technic. (See figure 2)

On March 7, 1967, the right inguinal herniorrhaphy was performed. An indirect inguinal hernial sac was found in the usual position containing two similar fragments of fibromembranous tissue, the largest one measuring 30 by 10 by 0.2 cm. The smaller one measuring 15 by 6 by 0.2 cm. Both specimens contained several cysts of 2 cm. in greatest diameter. The content was clear fluid. The remaining of the herniorrhaphy was completed according to the standard technic described by McVay and Holsted. (See figure 3)

Both para-inguinal incisions healed well. The hospital course was uneventful and the patient was discharged for follow-up visits, but failed to report. In 1969, he was readmitted to another hospital because on several occasions he had general malaise, marked ascites, pleural effusion, and multiple subcutaneous adominal masses. The ascitic fluid, as well as the pleural fluid, and the biopsy of the subcutaneous masses, all showed what was labeled "metastatic adeno-carcinoma". The primary site was then unknown.

This in our opinion has several interesting aspects.

1. The diagnosis was made through a bilateral inguinal herniorrhaphy, which included limited exploration of the peritoneal cavity through the internal ring.

2. At the time of the herniorrhaphy the specimen revealed marked granulomatous inflammation and mesothelial proliferation, which appeared to be limited to the peritoneum and to be viewed as a benign form. This was confirmed in 1970 to be malignant mesothelioma, the neoplasm evolved from a benign form to a highly malignant one. It was, indeed, a unique neoplasm of the peritoneum. At its final stage it had involved the pleura. This suggests the fact that this malignancy may be capable of invading the peritoneum and pleura either



Figure 2—Hernial sac, open and exposed, shows the abnormal content made up of cystic and fibrous tissues.



Figure 3—These are specimens removed from the peritoneal cavity through the internal inguinal ring, the longest one measuring 30 by 10 by 2 cm. They are plaques and filaments of membranous tissues with shiny and nodular appearance.

at the same time or at different stages. After all, pleura and peritoneum have the same anatomic and histologic structure fundamentally.

In one report, average survival rate (calculated on the basis of 29 cases) was about 20 months. These were of the diffuse type of mesothelioma. Of the localized or nodular type, there were three which were operated upon and of these only one appears to be well controlled five years after surgery.

Of 38 cases reported by Ribacchi,[6] only two were treated with colloidal gold (radioactive) injected into the peritoneal cavity. These two patients were alive and well six years after the first treatment. The mesothelioma was found to be limited to the peritoneum only in 85 per cent of cases reported in one series and spread or was taking place in other locations of the abdomen in 20 of the 35 cases. We cannot comment on our case as far as the diffusion of this neoplasm is concerned, because the patient refused exploration.

Conclusion

1. The mesothelioma has been recognized lately as the primary neoplasm of the mesothelium, having highly neoplastic qualities (capable of causing death in relatively short periods of time.)

2. Those patients (especially those of the middle age) exhibiting vague, mild abdominal symptoms or low grade fever should be thought of as possibly carrying such neoplasm. Exploration of the abdomen should be carried out for immediate diagnosis and selection of the method of treatment.

3. Ascitic fluid found in the hernial sac should be suspected as due possibly to the mesothelioma, and cytologic studies should be carried out.

4. The mesothelioma can affect the young patient, although it appears to be more common in the middle aged or elderly, and in the male more than the female.

5. Asbestos has been implicated in the development of this tumor, but in many cases, like ours, such a factor was absent.

6. We urge our colleagues to be more on the look-out for this malignancy as, if treated early, life expectancy may be improved considerably.

7. This case was diagnosed through a bilateral inguinal herniorrhaphy, at which time viscid peritoneal fluid was noted coming through the internal inguinal ring. The viscidity of peritoneal fluid is due to the presence of yaluronic acid, which is found in primary tumors of the peritoneum.

8. The incidence of this tumor has been reported from some centers to be 0.1 per cent of all autopsy cases for malignant tumors and 1.23 per cent of all primary and secondary tumors of the peritoneum.

9. This tumor has a high clinical malignancy and a low biologic malignancy.

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SUPPORT THE WIDOWS AND ORPHANS SOCIETY

Blood chemistries on trained athletes revealed a high frequency of some abnormal test results ascribed to exercises and high protein diets.

Influence of Exercise and High Protein Diet on Blood Chemistry*

A Study of Athletes

Irwin A. Oppenheim, M.D. and Donald F. Shields, M.D./Point Pleasant

Automated multichannel blood chemistry profiles are widely used in modern practice. The normal ranges (printed on the instrument recording paper) are commonly used in interpretation of test results. Little attention has been given to conditions which may influence these results and circumstances under which established "normal" ranges may not apply. This communication illustrates the importance of the effects of high protein diet and exercise. Several parameters may be significantly affected.

At the Point Pleasant Hospital Laboratory a unique opportunity occurred to study the blood chemistry profiles of a group of young, healthy, conditioned, professional athletes on a high protein diet.

Twelve-channel chemistry profiles were performed on each of twenty-one members of an ice hockey team. We used the Technicon SMA 12/60 after a period of normal ambulatory activity. Quality control was acceptable and within 95 per cent limits of confidence utilizing the technics of the American Society of Clinical Pathologists. The athletes were aged twenty to twenty-four and were, with one exception, in a two-hour post-prandial condition. Blood counts and urinalysis on each of the twenty-one athletes were within normal limits.

For purposes of comparison of the results on our healthy subjects, a series of profiles on two-hundred of our hospitalized patients chosen at random was also evaluated.

Deviations from the normal occurred in more than 5 per cent of each profile parameter tested in the group of athletes. Some of the greatest frequencies of abnormals were elevations of BUN, uric acid, total protein, and albumin in respectively 52, 62, 28, and 90 per cent of the cases. A remarkable number of abnormal results were similarly observed in the SGOT and LDH in 43 per cent and 45 per cent of cases respectively. Alkaline phosphatase also showed an unusual number of abnormals (28.5 per cent).

Results obtained in our series of healthy athletes were unexpected. One would expect[1] normal, healthy subjects to have chemistry profiles within established normal ranges or show a statistically expected deviation from normal in no more than 5 per cent of cases. Fites, *et al.*,[2] in chemistry profiles on one hundred and twenty-two young, healthy males found only zero to 6 per cent abnormalities in eight identical parameters; however there were 23 per cent abnormals in alkaline phosphatase. These authors did not comment on the increase in alkaline phosphatase. We are not particularly concerned with the 28 per cent abnormalities in our own series as it is known[3] that serum specimens for alkaline

*This work is from the Department of Pathology, Point Pleasant Hospital, Point Pleasant, where Dr. Oppenheim is Chief Pathologist and Laboratory Director. Dr. Shields is Associate Pathologist.

phosphastase will increase slightly in value on standing. Non-fasting specimens have been reported[4] to show borderline increased values. Most of the increases in our series are small and could be attributed to the non-fasting state and the interval between drawing the specimens and testing.

A study by Jutzy and Defragaso[5] on cases utilizing a profile identical to ours on hospitalized (non-healthy) patients revealed abnormal results in the different tests with frequencies ranging from 0.4 per cent to 27.7 per cent. The ratio of abnormals for albumin, total protein, SGOT, LDH, BUN, and uric acid was greater in our healthy, young, hockey players than in their hospitalized patients. An even more impressive comparison can be made with the report[6] from the Community Hospital, Salem, Massachusetts, where the greatest proportion of abnormalities of any parameter on a similar profile was 15 per cent.

In comparing our athlete's profiles with our own series of two hundred hospitalized patients chosen at random at our institution, results were similar and again showed abnormalities with a greater frequency for the athletes than for the hospital population. The comparison of the profiles of the healthy hockey players and our own hospital population is also impressive particularly in the SGOT, LDH, total protein, albumin, uric acid, and BUN determinations. It is entirely unexpected that healthy individuals would show such a substantial number of abnormalities in these tests and that they would show more abnormalities than in the hospitalized subjects.

Why did these healthy young athletes produce so many more abnormal results than the hospitalized patients? Why did they differ from what might be expected in a normal group of individuals?

Enzyme results, SGOT, and LDH were elevated above the normal range in almost half of the cases. Although the statement has been made[7] that the reported effects of exercise and eating do not affect an enzyme such as SGOT, the overwhelming evidence in the medical literature is opposed to this view. Fowler, *et al.,* in a study of enzyme levels after exercise in trained and untrained subjects, noted increases in serum enzymes. Rose, Bousser, and Cooper[9] also noted significant rises in serum enzymes after exercise and cited the work of Atland, Highman, Davison, and Fine.[10] Each felt that the skeletal muscle release of enzymes was due to necrosis or altered cellular permeability. McKechnie, *et al.,*[11] even recorded persistent serum enzyme elevations for weeks after a marathon run. Wolfe, *et al.,*[3] also called attention to elevated blood levels of SGOT and LDH after exercise.

Our data reinforce the previous reports that exercised subjects may have significantly elevated levels of serum enzymes such as SGOT and LDH owing to release of the muscle isoenzyme components.

Examination of the data obtained on total protein and albumin also showed unexpected high results most striking in the case of albumin where 90 per cent of the values were above the upper limits of normal. It is noteworthy that in SMA 12/60 profiles (Ludvigsen and Taylor)[12] the albumin on young, male, apparently healthy individuals also exceeded the upper limits of the chart value. Dehydration could be considered as a possible explanation based on other reported experiences in athletes,[13] however, in our study this is not plausible, since normal hemoglobins and hematocrits ruled out hemoconcentration. There was also a sufficient interval between exercise and testing for adequate rehydration. The explanation must be sought in other mechanisms. Factors related to the high protein diet and strenuous exercise must be considered along with a possible increase of circulating corticosteroids with a shift of amino acids from the muscle to the blood.[14]

It would appear that the 52 per cent abnormal results in BUN determinations are also in some way related to the increased protein

metabolism of our subjects, for the body can utilize only a limited amount of protein for synthesis or storage; hence on a high protein, high caloric diet the excess protein is catabolized with increases in blood urea values. Addis[15] has emphasized that the amount of protein in the diet has a profound influence on the amount of urea in normal persons as well as those with kidney diseases. Also we cannot exclude a possible additional factor increasing the BUN of our subjects: reported inhibition of renal function following severe exercise.[16]

Hyperuricemia in athletes has been observed repeatedly.[17, 18] According to Horvath's studies,[17] the increases are noted preferentially when the athletes are in training rather than when they are in periods of rest. In our series this occurred in 62 per cent of the cases. Among the mechanisms postulated are:[17, 19, 20] high protein diet and excessive intake of yeast with nucleoprotein catabolism, decrease in glomerular filtration, tubular dysfunction and increases in blood lactate. These factors may be additive to the finding that some of the highest mean values of uric acid in the Tecumseh studies [21] were found in males aged twenty to twenty-four.

None of the cholesterol results was elevated above the upper limits of normal of the chart paper and two values were below the lower limit with the majority of results markedly below the upper limit of normal. It must now be recognized, with the work of Frederickson, Levy, and Lees,[22] that the established limits of normal are age and sex, dependent with the upper limits below 300 milligrams per cent.[23] It is, therefore, not surprising that in our study values were skewed toward the lower limit when compared with the recording paper normal range. The physical activity of our subjects may be a contributory factor; however, the effects of exercise on lowering blood cholesterol are at the present time inconclusive.

We believe that with uric acid and cholesterol test results, the time has come to include sex and age modifications of the normal ranges on profile reports. However, in the case of sporadic individuals on high protein diets and in exercise training, established normal ranges cannot accommodate such patients.

In view of our findings and previous documented reports it is clear that individuals on high protein diets or significantly engaged in physical training and exercise have physiologic changes affecting blood chemistries and do not conform to accepted norms. With the life styles of the present, the interest in high protein nutrition and physical exercise pursued by the public, today's physician must take into account the diets and physical activities of his patients when interpreting chemistry data from the laboratory.

Summary

Chemical profile analysis of blood from twenty-one trained athletes revealed an unusually high frequency of abnormal test results in SGOT, LDH, BUN, uric acid, total protein, and albumin. High protein diets and exercise were responsible for these changes. Interpretation of chemistry tests and profiles should take into account possible dietary and exercise factors.

A bibliographic listing of 23 citations is available from the author.

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In spite of many claims to the contrary, none of the usually recommended medications is found superior to the others in the treatment of mental impairment in the aged.

Psychotropic Drugs in Old Age*

D. Peter Birkett, M.D. and Bruce Boltuch, M.A./Paramus

The claim is not infrequently made[1, 2] that one or other of the antipsychotic drugs (the phenothiazines, butyrophenones, and thioxanthines) is of special merit in the treatment of the psychiatric disorders of the senium. And indeed, there is accumulating evidence[3] that they are useful in geriatric psychiatry. Most of the claims to particular geriatric application have been made on behalf of thioridazine and haloperidol.[1, 3] A recent double blind comparison[1] between these two drugs in psychogeriatric patients revealed no significant difference in their psychotropic efficacy. However, their alleged lack of deleterious side effects in the aged seemed to warrant further investigation.

Postural hypotension, falls, drowsiness, tremor, abnormal movements, and rigidity, have been the most troublesome of these side effects with phenothiazines in the elderly.[2] The first two of these appeared objective enough to be studied in an open trial. Accordingly, an open crossover study of the side effects of thioridazine, chlorpromazine, and haloperidol was carried out.

There were 30 psychiatric patients over the age of 65 in the psychogeriatric unit at Bergen Pines County Hospital, in whom a trial of psychotropic drugs was considered ethically and clinically justified. Patients were excluded if they were already stabilized on a psychotropic drug which seemed beneficial to them, if their mental symptoms consisted only of confusion and memory loss, or if they had previously shown adverse reactions to phenothiazines, or if there was evidence of liver disease.

All other patients in whom a trial of different psychotropic drugs seemed clinically warranted were admitted to the project, until 30 subjects had been studied.

Dosage Schedule

The 30 patients remained a week without any phenothiazine, butyrophenone, or thioxanthine type drug. Then they were assigned at random to one of three groups of ten patients each.

One group of ten patients received drugs according to the following schedule (all drugs given in single evening doses):

Day 1: Haloperidol 0.5 mg.
Day 2: Haloperidol 1 mg.
Day 3: Haloperidol 2 mg.
Day 4: Thioridazine 25 mg.
Day 5: Thioridazine 50 mg.
Day 6: Thioridazine 100 mg.
Day 7: Chlorpromazine 25 mg.
Day 8: Chlorpromazine 50 mg.
Day 9: Chlorpromazine 100 mg.

The second group of 10 patients received the following:

Day 1: Chlorpromazine 25 mg.
Day 2: Chlorpromazine 50 mg.
Day 3: Chlorpromazine 100 mg.
Day 4: Thioridazine 25 mg.
Day 5: Thioridazine 50 mg.
Day 6: Thioridazine 100 mg.
Day 7: Haloperidol 0.5 mg.
Day 8: Haloperidol 1.0 mg.
Doy 9: Haloperidol 2.0 mg.

The third group of 10 patients received the following:

Day 1: Thioridazine 25 mg.
Day 2: Thioridazine 50 mg.
Day 3: Thioridazine 100 mg.
Day 4: Haloperidol 0.5 mg.
Day 5: Haloperidol 1.0 mg.
Day 6: Haloperidol 2 mg.
Day 7: Chlorpromazine 25 mg.

* From the Bergen Pines County Hospital, Paramus, New Jersey.

Day 8: Chlorpromazine 50 mg.
Day 9: Chlorpromazine 100 mg.

Observations

Postural hypotension: Blood pressures were initially recorded during the drug-free period, by a physician, with the patient recumbent. Subsequently they were recorded each morning by a nurse, with the patient standing, within an hour of rising (i.e. 11 to 12 hours after the previous night's medication had been given).

Falls: These were to be recorded as separate incidents by the nursing staff (in the event no patient fell during the time of study).

Tremors, drowsiness, rigidity, and abnormal movements: These were graded 1, 2, or 3 (mild, moderate, or severe) by the physician during each day of the study. If any of these were already present they were ignored, unless they increased in severity while the drugs were being given.

Unsteadiness on the feet: This was graded 1 for anything less than complete steadiness, 3 for inability to walk unaided, and 2 for anything in between.

Results

Systolic blood pressure: This fell most on thioridazine and least on chlorpromazine, but the results were not statistically significant. The 90 standing morning systolic blood pressures on thioridazine had a mean of 5.4 millimeters less than the initial recumbent systolic blood pressure. This mean for haloperiodol was 1.9 millimeters, and for chlorpromazine 0.7 millimeters. (For the difference between the means for thioridazine and chlorpromazine, t was —1.42).

Diastolic blood pressure: This fell most on thioridazine and least on chlorpromazine, but the results were not statistically significant. The 90 standing morning diastolic blood pressures on thioridazine had a mean of 4.8 millimeters less than the initial recumbent diastolic blood pressure. This mean for haloperidol was 2.4 millimeters, and for chlorpromazine 2.2 millimeters. (For the difference between the means for thioridazine and chlorpromazine, t was —1.41).

Other side effects: None of the between drug differences was of apparent clinical importance or of calculable statistical significance. The numerical grades indicated for each separate side effect were multiplied by the number of days on which each was observed so as to give a "side effect score" for each drug, to which statistical formulae were applied.

Unsteadiness on the feet and rigidity were greatest on haloperidol. Drowsiness was greatest on chlorpromazine, and tremor on thioridazine. There were no falls or other accidents during the course of the trial.

None of the three drugs was found to be especially low in side effects. In conjunction with the results obtained by the Boston group,[1] this study might suggest that none of the three psychotropic drugs studied is superior to the others for elderly patients.

The open nature of the trial reduces the validity of the subjective observations, but it seems likely that any clinically important difference in effects on blood pressure would have been picked up.

Summary

The incidence of postural hypotension and certain other side-effects, produced by three psychotropic drugs, in elderly patients, was compared in an open cross-over trial.

The drugs compared were thioridazine, chlorpromazine, and haloperidol. None was found to show any particular advantage.

References

1. Min-Min, T., *et al.: Journal of the American Geriatrics Society*, 19, 593 (1971)

2. Felger, H. L. *Diseases of the Nervous System*, 27, 537 (1966)

3. Birkett, D. P. and Boltuch, B. *Journal of the American Geriatrics Society*, (in press).

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1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
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Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

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Cholestatic hepatitis with jaundice and altered liver function tests, su as increased BSP retention and rises in SGOT levels, have been reporte after Methyltestosterone. These changes appear to be related dosage of the drug. Therefore, in the presence of any changes in liv function tests, drug should be discontinued.

PRECAUTIONS: Prolonged dosage of androgen may result in sodium ar fluid retention. This may present a problem, especially in patien with compromised cardiac reserve or renal disease. In treating mal for symptoms of climacteric, avoid stimulation to the point of increa ing the nervous, mental, and physical activities beyond the patient cardiovascular capacity.

CONTRAINDICATIONS: Contraindicated in persons with known or su pected carcinoma of the prostate and in carcinoma of the male breas Contraindicated in the presence of severe liver damage.

WARNINGS: If priapism or other signs of excessive sexual stimulatic develop, discontinue therapy. In the male, prolonged administration excessive dosage may cause inhibition of testicular function, wi resultant oligospermia and decrease in ejaculatory volume. Use cau lously in young boys to avoid premature epiphyseal closure or pr cocious sexual development. Hypersensitivity and gynecomastia m occur rarely. PBI may be decreased in patients taking androgen Hypercalcemia may occur, particularly during therapy for metast breast carcinoma. If this occurs, the drug should be discontinued.

ADVERSE REACTIONS: Cholestatic Jaundice • Oligospermia and d creased ejaculatory volume. • Hypercalcemia particularly in patien with metastic breast carcinoma. This usually indicates progression bone metastases. • Sodium and water retention. • Priapism • Vir zation in female patients • Hypersensitivity and gynecomastia.

DOSAGE AND ADMINISTRATION: Dosage must be stricly individualize as patients vary widely in requirements. Daily requirements are be administered in divided doses. The following chart is suggested as a average daily dosage guide.

INDICATION	Average Daily Dosag Tablets
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Hopeful results are here reported with radiotherapy of rectal carcinomata.

Radiotherapy of Carcinoma of the Rectum*

Louis J. Sanfilippo, M.D./Livingston

Cure rates for carcinoma of the rectum have shown little if any improvement in recent years.[2] Five-year survival with surgical resection is 50 per cent.[8, 15] It is only 30 per cent when lymph node metastases are present. Improved survival must come from detection of cancers at an earlier stage, and from development of surgical adjuvants.

Evidence suggests that radiotherapy may be of real value in treatment of adenocarcinomas of the rectum, including the rectosigmoid.[1, 2, 5, 11, 21] The classical view that these tumors are radioresistant[12] must be reassessed.

Preoperative Irradiation

Preoperative irradiation is intended to reduce tumor bulk, reduce tumor stage, enhance resectability, and reduce the risk of surgical dissemination.

The oldest study with preoperative x-ray therapy for cancer of the rectum and rectosigmoid is from Memorial Hospital (N.Y.).[13, 17, 18] Analysis was made of 901 patients who received "curative resections" from 1939 to 1951.[18] Estimated tissue doses ranged from 1,200 to 2,000 rads.[10] Often, this produced tumor shrinkage and reduction in inflammatory changes.[13] No difference in survival was seen in irradiated cases with cancer limited to the bowel wall (Dukes' A) or penetrating the serosa (Dukes' B). However, the five-year survival was improved for treated cases with lymph node metastases (Dukes' C): 43 per cent versus 27 per cent with surgery alone. In 1957, the Memorial group initiated a trial with pelvic irradiation of 2,000 rads in two weeks with Cobalt-60. Preliminary review in 1968 did not confirm earlier findings.[18]

The VA Surgical Adjuvant group has published encouraging results with preoperative irradiation in a controlled study of 700 individuals with resectable cancer of the sigmoid colon and rectum.[3, 14] Irradiated cases received 2,000 to 2,500 rads to the pelvis in two weeks. This was followed by immediate surgery.

Pathologic findings in the resected specimens of the treated versus the control group revealed reduction in incidence by 23 per cent with lymphatic invasion, 20 per cent with serosal penetration, and 35 per cent with positive nodes. Differences in the study were greatest for those having abdomino-perineal resections (70 per cent of the total). The irradiated cases had a projected five-year survival of 45 per cent compared with 30 per cent in controls. Positive nodes were present in 26 per cent of the irradiated group, and in 43.7 per cent in controls.

The Yale-New Haven Hospital has conducted a pilot program with more intensive preoperative irradiation, using a 6 million volt linear accelerator.[5, 10] Thirty-three resectable rectal and rectosigmoid carcinomas were

*Read before the New Jersey Gastroenterologic Society, October 11, 1972. Dr. Sanfilippo is Director of Radiotherapy, Saint Barnabas Medical Center, Livingston, New Jersey.

treated with 4,500 rads to the primary tumor, pelvic nodes, and hemorrhoidal lymph node chains (to L2) in one month. Radiation was well tolerated; diarrhea occurred in 70 per cent but was easily controlled. Ten per cent had skin reactions in the gluteal fold. Resection was done one month later. Postoperative complications in irradiated cases were similar to cases with surgery alone. Review of the 31 irradiated surgical specimens revealed an increase in early stage and a sharp reduction in advanced stages compared with the expected incidence: Dukes' Stage A—66 per cent *vs.* 27 per cent; Stage B—12.5 per cent *vs.* 30 per cent; Stage C—22 per cent *vs.* 43 per cent.

The University of Oregon Medical School has used even higher dosage preoperatively for rectosigmoid carcinomas.[1] Using Cobalt-60 or 2 million volt x-rays, 5,000 rads were given in five and a half weeks in 50 resectable cases. Treatment portals encompassed the primary tumor and adjacent tissues only, and usually measured 10 by 10 centimeters. Resections, primarily abdomino-perineal, were performed 4 to 6 weeks later without increase in surgical complications. The surgical specimens showed complete tumor destruction in 10 per cent, and carcinoma *in situ* in 10 per cent more. Lymph node metastases were seen in only 20 per cent. The local recurrence rate was zero in 1 to 10 years. Survival without disease was 70 per cent in 1 to 10 years compared with an expected 54 per cent.

Both the Yale and Oregon groups reported partial success in making inoperable tumor resectable.[1,21] With 4,500 rads, 9 of 16 cases became resectable, 3 surviving free of disease at 5 years. With 5,000 rads, 10 of 22 became resectable with 3 patients living without recurrence at 30 months.

Postoperative Irradiation

No data are available regarding the value of postoperative irradiation, except for isolated case reports.[21] A review of 2,000 surgical cases at St. Mark's Hospital, London, revealed that the risk of pelvic recurrence is highest (15 to 20 per cent) for tumor of the lower rectum, those with extensive local spread, and those of high grade malignancy.[8] Cases in these categories are receiving a clinical trial at St. Mark's, with postoperative pelvic irradiation of 5,000 rads in 5 to 6 weeks.

Curative Irradiation

Papillon,[11] has shown that limited adenocarcinomas of the rectum are curable with endocavitary irradiation. These may show great radiosensitivity.[11] Tumors suitable for this treatment must be accessible—less than 14 centimeters from the anus, not greater than 5 centimeters in length and 3 centimeters in width, and polypoid in type, with little infiltration.

Irradiation was given primarily with contact x-ray therapy (Phillips Unit). These units emit x-rays of low energy (45 to 50 Kv.), are used at short source-skin distances (2 cm), and have tremendous cumulative outputs (up to 6,000 R per minute). The depth dose at 10 millimeters is less than 20 per cent of the surface dose.[9] The x-ray tube head is mounted near the end of a long cylindrical nozzle. This apparatus has been adapted by Papillon[11] so that it can be inserted into the rectum, and the applicator surface placed on the tumor. Maximum total tumor doses of up to 11,000 rads were given in 3 to 4 treatments, a week apart. A few were also treated with radium implants, alone, or combined with contact x-ray therapy. Maximum radium dosage was 6,000 rads in 3 to 4 days.

Results were remarkable. Of 105 cases, 66 per cent survived free of disease for 5 years, with 6 per cent local recurrence cured by surgery. Intercurrent disease claimed 12 per cent. Necrosis in the tumor site occurred in 8 cases, six healing with medical treatment.

Palliative Irradiation

Ralston Paterson,[12] has stated that adenocarcinoma of the rectum is essentially radioresistant. He holds that low or moderate doses do not palliate, and high doses produce such severe reactions they outweigh the benefits achieved. Several authors refute this

view.[16, 21, 22, 23] They report palliation in a high proportion of irradiated cases, with tolerable local and systemic reactions. Williams[23] reviewed 82 cases of recurrent rectal carcinoma treated with one million volt x-rays. He gave doses of 4,000 rads for local palliation and 6,000 rads for limited, potentially curable disease. Symptoms, predominantly plain, were relieved in 87 per cent. Relief was sustained for an average of 7.7 months before death. Average survival was one year. Ten per cent were alive and well for 1 to 10 years.

Wang and Schulz[22] reported on 111 cases of recurrent, residual, or inoperable cancer of the sigmoid colon and rectum.[22] Significant relief of pain, arrest of bleeding and discharge, and shrinkage of tumor masses occurred in 84 per cent with doses of 2,000 to 5,000 rads. Duration of response was over 6 months in 12 per cent treated with doses of 2,100 to 3,000 rads, 31 per cent with 3,100 to 4,000 rads, and 58 per cent with 4,100 rads or over. Six of 58 cases with cancer confined to the pelvis were well for 5 or more years.

Smedal[16] published a series of 50 recurrent rectal carcinomas treated with 2 million volt x-rays. Doses up to 6,000 rads produced palliation of six months to over one year in one-half of the cases. Nonmucin producing tumors were found to be most radiosensitive.

The Yale-New Haven Hospital group analyzed 102 cases of primary inoperable rectal and rectosigmoid cancer and recurrent cancer of the rectum treated with 6 million volt x-rays.[21] Symptoms were relieved in 80 per cent with tumor doses up to 6,000 rads. Palliative irradiation achieved better survival than palliative surgery. Colostomy was avoided in 71 per cent of 35 potential candidates, although all died of their disease.

Few studies are available of palliative irradiation combined with chemotherapy. Millington[6] reviewed 37 cases of recurrent or inoperable rectal carcinoma treated with systemic 5 FU and 3,000 rads pelvic irradiation with cobalt-60. The 5 FU was given concurrently in doses of 15 mg/Kg body weight for 5 days, followed by one-half the dose on alternate days for 6 more times. Symptomatic relief occurred in 80 per cent and objective regression in 46 per cent. Six patients remained alive and well over four years. Localized recurrences responded better than extensive pelvic spread. Drug toxicity developed in almost all patients, but was reversible, except for one case of fatal marrow aplasia.

The Mayo Clinic reported[7] on locally unresectable large bowel carcinoma without metastases treated with Cobalt-60 or 6 million volt x-rays. A tumor dose of 3,500 to 4,000 rads was given to 65 patients in a random double blind study: concurrent 5 FU-15 mg/Kg/day for 3 days or placebo at the start of radiotherapy. Reversible gastrointestinal toxicity and leukopenia were noted with 5 FU. The 5 FU treated cases had significantly increased clinical control of their disease. However, the prolonged mean survival with 5 FU, 22.5 months vs. 16.8 months with placebo, was not statistically significant.

Discussion

Cited studies indicate that pre-operative irradiation of rectal and rectosigmoid carcinomas, even in modest doses, appears capable of destroying peripheral tumor extensions and lymph node metastases in a significant proportion of cases. (Well oxygenated tumor cells at the periphery of the tumor, or in nests within lymph nodes, may be more radiosensitive by a factor of nearly three, compared with hypoxic tumor cells at the core of the main mass.)

Higher dosages of 4,500 rads or more actually sterilized tumors. At least, they produced moderate to marked radiation effect in most cases. Tumor cells that were not destroyed may well have been rendered reproductively impotent, a characteristic injury of ionizing radiation.

Irradiation, therefore, may prove to be an important surgical adjuvant and improve survival by reducing local recurrence and local and systemic surgical dissemination. Signifi-

cance of iatrogenic metastases has been well demonstrated by Turnbull.[20] He doubled cure rates in Dukes' Stage C cancers of the mobile portions of the colon using a "no touch isolation technic" of surgical resection.

Our own limited experience at Saint Barnabas Medical Center with preoperative irradiation of local advanced, borderline operable, or initially non-resectable lesions is encouraging. Pelvic irradiation of 4,000 to 4,500 rads in 4 to 4½ weeks given with the 6 million volt linear accelerator has been well tolerated. It has not produced increased postoperative complications after abdomino-perineal resection. Partial tumor shrinkage, enhanced resectability, and marked irradiation effect on tumor cells has been observed in almost all cases. Continued trial with this approach and possibly a cooperative study with other institutions is recommended.

The role of chemotherapy in treatment of rectal cancer remains unclear. Recent reports[4] suggest fluorouracil improves survival when given postoperatively and is additive when combined with x-irradiation.[6, 7] Therefore, it may ultimately prove of value as an adjunct to both surgery and irradiation.

Conclusions

1. Preoperative irradiation of rectal and rectosigmoid carcinomas with doses of up to 5,000 rads is feasible and promises to be an important surgical adjuvant.

2. Limited rectal adenocarcinomas are radiocurable with endocavitary irradiation.

3. Palliative megavoltage irradiation of recurrent or inoperable disease is effective in a high percentage of cases, but rarely achieves long term control.

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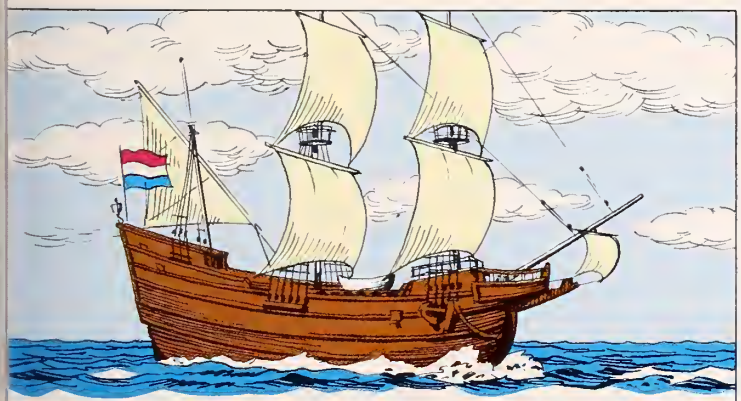
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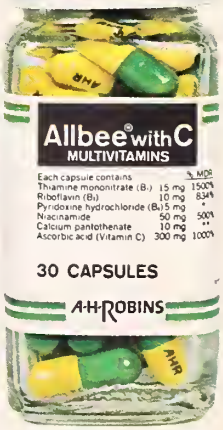


RONSSENS, A DUTCH PHYSICIAN, WROTE IN 1564 THAT "DUTCH SAILORS WHO, RETURNING FROM SPAIN, WERE ATTRACTED BY THE NOVEL RICHNESS OF THE FRUIT (ORANGES) AND BY THEIR GREED AND GLUTTONY, UNEXPECTEDLY DROVE OUT THE DISEASE (SCURVY), AND HAD THIS HAPPY EXPERIENCE NOT ON A SINGLE OCCASION ONLY, BUT REPEATEDLY."

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Here reviewed and documented is considerable experience in one 130-bed specialized hospital in our state.

Cardiac Surgical Mortality for Adults at the Deborah Heart and Lung Center

Joseph Esterson, M.D., et al.*
Browns Mills

The Deborah Heart and Lung Center has been doing heart surgery since 1958. The number of treated patients has increased steadily since then and the hospital is now the major center for open heart surgery in New Jersey (306 open heart operations were done in 1971). Although the mortality associated with some types of defects has improved, patients with more advanced stages of heart disease have become candidates for surgery.

This is a statistical review of in-hospital, immediate surgical mortality for adults over the 18-month period from January 1, 1971 to June 30, 1972. Early mortality is only one indicator of the results of surgical treatment and this report does not consider other important factors such as morbidity and late mortality.

Diagnostic evaluation including clinical examination, x-rays, and ECG-VCG preceded all decisions for open-heart operations. Also exercise testing and cardiac catheterizations were performed when indicated. Mitral and tricuspid valve replacements were with the Beall prosthesis and aortic valves were replaced with the Bjork-Shiley prosthesis. All of the coronary artery procedures were saphenous vein aorto-coronary by-pass grafts, and a few patients had endarterectomies or aneurysmectomies in addition. Total corrections for tetralogy of Fallot included closures of ventricular septal defects, relief of pulmonic obstructions, and ligation of previous surgical systemic-pulmonary shunts. The pacemaker procedures were largely transvenous implantations; many were for battery replacements.

Patients with open-heart surgery were treated in the intensive care unit for only two days, unless severe complications necessitated longer stays. They were then gradually ambulated beginning on the fourth post-operative day. Anticoagulants were routinely administered after all valve replacements, the dosage adjusted according to prothrombin time determinations. Antibiotics were given on the day of surgery for two days post-operatively.

Results for immediate in-hospital mortality should be assessed in comparison with the results of other institutions. Aortic valve surgery (Table 1) compares favorably with two of the larger more recently reported series: mortalities of 13 per cent and 11 per cent respectively. [1, 2] Our mortality for mitral valve replacements (3.7 per cent) also compares favorably to other recent large series:[1, 2] 16.2 per cent and 31.5 per cent. Because all mitral commisurotomies are performed with the open technics, operations for "restenosis" have been rare. Principal causes of death following valve surgery were heart failure and pulmonary emboli.

*This work is from the Departments of Cardiology and Cardiovascular Surgery, Deborah Heart and Lung Center, Browns Mills, New Jersey. Coauthors are Alden S. Gooch, M.D., Dryden Morse, M.D., Javier Fernandez, M.D., and Vladir Maranaho, M. D.

TABLE I

Valvular Surgery

	No. of Patients	Mortality	Per Cent
Mitral valve			
Commissurotomy and/or annuloplasty	42	1	2.4
Replacement	54	2	3.7
Aortic valve			
Replacement	70	0	0
Commissurotomy	17	0	0
Mitral and aortic valves			
Replacement of both	28	8	29.0
Commissurotomy of both	4	0	0
Aortic replacement and mitral commissurotomy	13	1	7.7
Mitral replacement and aortic commissurotomy	2	0	0
Tricuspid valve surgery alone (1 plication and 1 replacement)	2	0	0
Mitral and/or aortic surgery combined with tricuspid valve			
Tricuspid replacement	3	0	0
Tricuspid plication	12	2	16.5

Multi-valve surgery carries a higher mortality (29 per cent) as with the reported results of two other recent studies: 41 per cent of 56 patients,[2] and 35.7 per cent of 14 patients.[1] Major causes for the increased mortality in such patients include longer time required on cardiopulmonary by-pass, and the fact that patients who need this treatment have more severe and prolonged heart disease, and they are more prone to post-operative complications.

The mortality with coronary artery by-pass grafts (Table II) deserves comment. It is

TABLE II

Coronary Heart Disease Surgery

	No. of Patients	Mortality	Per Cent
Saphenous vein aortocoronary by-pass	97	9	9.3
Left ventricular aneurysmectomy	4	0	0
Aneurysmectomy combined with coronary by-pass	10	2	20.0
Coronary artery combined with valve surgery	12	1	8.3

difficult to make an accurate comparison with other series as indications for such surgery are controversial and patients have widely ranging degrees of symptoms and pathology. Our prime indication for surgery is intractible angina pectoris, unrelieved by medications including propranalol. No patients without severe unremitting complaints were operated upon. Principal contraindications include advanced pulmonary disease, obesity, and severe myocardial dysfunction. Favolaro[3] reports a low mortality (3.6 per cent) after treating 1,756 patients. Perhaps his cases included people selected with less rigid indications for surgery. Reul's group[4] and Field's group[5] had 6 per cent mortalities but did not mention pre-operative medical trials. Mitchel's[6] had 12 per cent mortality in patients after a failure with propranalol. Johnson[7] reported an operative mortality of 12 per cent even though one third of his patients were high risk with left ventricular failure. Spencer's group[8] had 8 per cent operative mortality (129 patients) with no patients with left ventricular failure (LVEDP greater than 25 millimeters of mercury). Our patients were operated upon after definite "medical failures." Relief of angina pectoris was the major goal. Whether coronary surgery prevents a significant number of myocardial infarctions is still a question. Two patients developed proximal coronary artery stenosis after aortic valve replacement and required jumpgraft surgery.[9] Other important problems are occasional postoperative occlusions of the venous grafts and intra-operative infarctions. If congestive failure is due to a discrete ventricular aneurysm, surgical resection is the treatment of choice.

Twelve patients had combined by-pass coronary grafts and valve (aortic or mitral) replacements with three deaths; one patient had both mitral valve replacement and aortic commissurotomy. The Cleveland Clinic [10] results were 8 per cent (50 patients) and the Marquette[11] group results were 54 per cent of 13 patients. Our numbers are still too small for definite statistical analysis, but combining the two types of operations apparently carries a higher mortality than either procedure alone.

A total of 153 patients were operated upon for the correction or palliation of congenital lesions. This report deals only with the adults, or 10.4 per cent of all the congenital

TABLE III

Congenital Heart Disease and Miscellaneous

	No. of Patients	Mortality	Per Cent
Congenital			
Atrial septal defect	8	0	0
Tetralogy of Fallot (total correction)	5	1	20.1
Coarctation of aorta	1	0	0
Atrial septal defect repair & mitral valve replacement	1	0	0
Ventricular septal defect (repair)	1	0	0
Miscellaneous			
Pacemarker insertions	48	0	0
Atrial myxoma (3 left, 1 right)	4	0	0
Aortic aneurysm (2 combined with aortic valve replacement)	4	1	25.0

hearts operated upon at Deborah (Table III). Patients with small shunts were not operated upon. One patient died after an open correction of tetralogy of Fallot. Although the mortality is low, the over-all numbers are insufficient for accurate comparison. Many of the patients with aortic stenosis had a congenital deformity as a basis for their lesion, but this distinction is not easily made and they were all included in the valvular surgery group.

This report indicates generally satisfactory progress in the operative palliation of certain types of heart disease. It also demonstrates areas in need of continued effort to lower further the risk of cardiac surgery.

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Women Smokers and Heart Attacks

Heavy cigaret smoking among women is blamed for a marked increase in sudden death from coronary heart disease among the feminine sex, in a report in the May 14, *JAMA.* This indicates that women are gaining steadily on men in frequency of sudden death from heart attack.

In the 1950's there were 12 sudden deaths in men from coronary heart disease for each one in women. In the late 1960's, the ratio had dropped to four to one. This shift has been associated with an increase in heavy cigaret smoking among women. Heavy cigaret smoking may cut a woman's life span as much as 19 years. Mean age for women dying suddenly of heart attack was 67 in the nonsmoker, 55 in the light smoker, and 48 in the heavy smoker. It was found that 62 per cent of the women dying suddenly from CHD were heavy cigaret smokers, as compared to only 28 per cent of those women who died suddenly from other causes.

Cigaret smoking is more lethal for women than for men in triggering sudden fatal heart attacks. Among men the ratio of smokers to nonsmokers in sudden death from coronary heart disease is three to one; among women the ratio jumps to nine to one.

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Opinion & Dialogue

"Prescription drugs – who should determine the maker?"

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President
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Maker of Medicine

C. Joseph Stetler
President
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"Too many doctors are indifferent to the economic consequences their decisions." So stated a recent issue of *Medical News Report* (December 4, 1972), an independent weekly newsletter published by for AMA Chief Executive F. J. L. Blasingame, M.D.

Doctor, are you indifferent...?

In discussing an anticipated crease in Blue Shield rates, Dr. Blasingame's newsletter had this to say:

"In general, it can be said, M have given the impression they are not particularly concerned with the increase in cost of health care to the patients...

"True, an MD's training is primarily scientific, but in the real world of practice, all of his scientific decisions have a price tag, or an economic impact. The economics of health c beckon the practitioner's attention Concern for economics of medicin

When the pharmacist recommends that a drug product other th the one ordered be dispensed, the prescriber invariably permits the change when he feels the best interests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is necessary for the prescriber to know that the change is being contemplated, and to be in a position to consent o demur. Without that opportunity, th unilateral decision of the pharmac made in the absence of clinical knowledge of the patient, could expose h to needless risks, and in addition, jeopardize the relationship betwee the professions of Pharmacy and Medicine. In my view, there is noth in the pro-substitution argument th offsets these risks.

The Issue of Drug Knowledge

Substitution advocates claim that the primary justification for changing the rules is the desire to better utilize pharmacists' knowled about drugs. Yet the pharmacist's task to keep current on the entire field of drug therapy, to some degr puts him at a disadvantage. Most often, a practicing physician will ne expert knowledge of no more than 2

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ould be an obligation of medical actice...

"Medical societies ought to conct continuing campaigns to point t the substantial savings that could realized thru deductible insurance d protection for catastrophic illss. At the very least, they should, in e patients' interest, question the ctics of any insurance organization at raises health care costs by forcg policyholders to buy insurance ey may not need or want and probly won't ever use.

"Too many doctors are indiffert to the economic consequences of eir decisions. Too many, for exnple, habitually hospitalize patients the convenience of the MD. It's nsense to deny such habits exist...

"Doctors, thru their medical soeties, have unhesitatingly appealed their patients for support in the ht against government interference th the private practice of medicine. id the public in the past has reonded. It's time the American Medal Association and state and local edical societies paid off the debt by cisive action to hold down the cost medical care."

st of Drugs

Insurance rates and hospital arges are only two factors in health care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

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30 drugs that he selects to treat the ajority of conditions encountered in s practice. Moreover, the physian's choice of a specific brand is sed on his knowledge of the pent's medical history and current ndition, and his experiences with e particular manufacturer's oduct.

Some substitution proponents ave argued that the dispensing of a escription is a simple two-party ansaction between the pharmacist nd the patient, and that a substitutg pharmacist may avoid even a chnical breach of contract by simply otifying the patient that he is making e substitution. I would judge that w courts would be sympathetic ward a pharmacist who substituted ithout physician approval and who ndertook a legal defense that seeks make the patient responsible for e pharmacist's actions.

educed Prescription Prices?

Substitution advocates are uggesting to the consumer, and parcularly the consumer activist, that educed prescription prices could llow legalization of substitution. /e have seen absolutely no evidence justify this claim. To the contrary, xperience in Alberta, Canada, where ubstitution is authorized, suggests the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands — of, say, ampicillin or tetracycline — or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advocates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

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P·M·A

Recommendations† on Combination Live Virus Vaccines

American Academy of Pediatrics

Committee on Infectious Diseases

In the September 15, 1971 *AAP Newsletter* sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."



United States Public Health Service

Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report*, the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately.
- "There is no evidence that adverse reactions to the combined products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations).
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."

†For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

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4 months	DPT Oral poliomyelitis vaccine (triple)
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1. This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.
Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

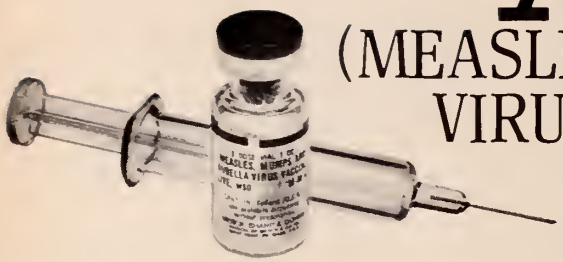
*Trademark of Merck & Co., Inc.

For a brief summary of prescribing information, please see following page.

M-M-R

(MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE | MSD)

Single-dose vials



No untoward reactions peculiar to the combination vaccine (M-M-R) have been reported.

Moderate fever (101–102.9 F) occurs occasionally. High fever (over 103 F) occurs less commonly. On rare occasions, children who develop fever may exhibit febrile convulsions. Rash (usually minimal and without generalized distribution) may occur infrequently.

Since clinical experience with measles, mumps, and rubella virus vaccines given individually indicates that very rarely encephalitis and other nervous system reactions have occurred, such reactions may also occur with M-M-R. A cause and effect relationship, however, has not been established.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Must not be given to women who are pregnant or who might become pregnant within three months following vaccination.

Contraindications: Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

Precautions: Administer subcutaneously; do not give intravenously. Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other *live* virus vaccines; vaccination should be deferred for at least six weeks following blood transfusions or administration of more than 0.02 cc immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles and mumps vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2–8 C (35.6–46.4 F) and *protect from light*. Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2–8 C (35.6–46.4 F), and discard after eight hours.

Adverse Reactions: Fever, rash; mild local reactions such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia and purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101–102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions.

Encephalitis and other nervous system reactions that have occurred very rarely with the individual vaccines may also occur with the combined vaccine.

Transient arthritis, arthralgia, and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. Such reactions have been reported with live attenuated rubella virus vaccines. Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after immunization should be considered as possibly vaccine related. Symptoms have generally been mild and of no more than three days' duration. The incidence in prepubertal children would appear to be less than 1% for reactions that would interfere with normal activity or necessitate medical attention.

How Supplied: Single-dose vials of lyophilized vaccine, containing when reconstituted not less than 1,000 $TCID_{50}$ (tissue culture infectious doses) of measles virus vaccine, live, attenuated, 5,000 $TCID_{50}$ of mumps virus vaccine, live, and 1,000 $TCID_{50}$ of rubella virus vaccine, live, expressed in terms of the assigned titer of the NIH Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin, with a disposable syringe containing diluent and fitted with a 25-gauge, 5/8" needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

MSD
MERCK SHARP & DOHME

Simple measures for the typical asthmatic child or the child with other chronic respiratory allergies are here suggested.

Management of Children with Chronic Respiratory Allergies

Michael S. Mattikow, M.D./Wayne

The child with chronic respiratory allergies is a challenge to the pediatrician and generalist in whose hands his daily management usually falls.

I am constantly amused by the patient who starts by saying: "I'm here because Dr. Smith sent me for skin tests." This shows a complete misunderstanding of the work of the allergist whose first job is to make a decision as to whether the symptoms are due to allergies, second, what the causes of the allergies are, and third, what is the best method of treating them?

It is usually easy to say whether the patient has allergies. Allergic patients tend to follow patterns and by taking a good history and doing a meticulous examination, the allergist usually can answer the questions; "Is the patient allergic?" and "What is the patient allergic to?" Skin tests are just laboratory tools used to confirm or disprove impressions obtained from the history and physical examination. False positive skin tests are frequent and if you try to treat patients on the basis of skin tests only, such as testing laboratories do, your results will be poor.[1]

To illustrate this point, I took 22 patients who, by history, had nasal and eye symptoms only during the fall ragweed season and tested them with grass, trees, and plantain which pollinate at times these patients were symptom free. Nineteen of 22 patients had positive skin tests to grass, 18 of 22 had positive skin tests to trees, 15 of 22 had positive tests to plantain. Yet, none of these patients had symptoms in the seasons when these pollens were prevalent.[2] If I had treated them on the basis of skin tests only, this would mean the injection of much useless and potentially dangerous material.

In an experimental environment, accurate diagnosis can be made by challenge experiments. If someone has asthma, he can inhale a nebulized dose of the suspected allergen. Pulmonary functions are done before, at 5, and at 30 minutes after the challenge. Obstructive defects are noted and accurate diagnoses are made.[3] The same thing has been done by Connell[4] with a machine for testing nasal allergies.

In vitro it has been shown that histamine is released from the leukocytes of sensitive patients when these leukocytes are exposed to the specific allergens the patient is allergic to.[5] Also, passively sensitized rat mast cells degranulate when mixed with specific allergens.[6]

Specific I.G.E. levels can be measured but are not practical for the office management of the allergic patient. This means, for the present, that the patient's allergens will continue to be diagnosed by the taking of a good history and by selective skin tests.

It is important to know what allergens are present in the patient's environment. For instance, what pollens are in this general area and what are their seasons of pollination? Plants pollinate in two separate ways. The heavy sticky pollens put out by flowers usually do not cause allergies since they stick to

insects which help cross-pollinate the plants. This means that such plants as roses and golden rod are not significant causes of allergic symptoms. However, the light wind-blown pollens which travel long distances are the ones we are concerned with.[7]

In northern New Jersey, where I live, the trees start pollinating some time in March and reach their peak in late May and early June.[8] In Figure 1, you will note that in a quantitive and qualitative pollen study done in Chilton Hospital in 1971, many different pollens were obtained from different trees. However, not all are of equal importance. Probably the oak, birch, elm, and maple are the most important allergens. Trees, as a rule, do not cross-react. Therefore, if one were to treat with a tree mixture of 6 to 8 pollens, good results would not be obtained. An attempt to find the specific trees giving symptoms is important.

Grasses start pollinating some time in late May and peak in late June.[10] (Figure 2) They may go on pollinating into August. Unlike the trees, probably all northern grasses contain a common antigen and mixes containing many different types of grasses are unwarranted.[11] Probably timothy, orchard, and June is a sufficient mixture to use for treating people with grass allergy in the Northeast. English plantain and sheep sorrel (Figure 2) also pollinate around the time of grass.[12] However, they are of lesser importance. Ragweed (Figure 2) begins to pollinate in late August and continues through until frost.[13] There are lesser fall pollens, such as cocklebur, mugwort, chenopodium, amaranth, and the like, which, in individual patients, may be important.

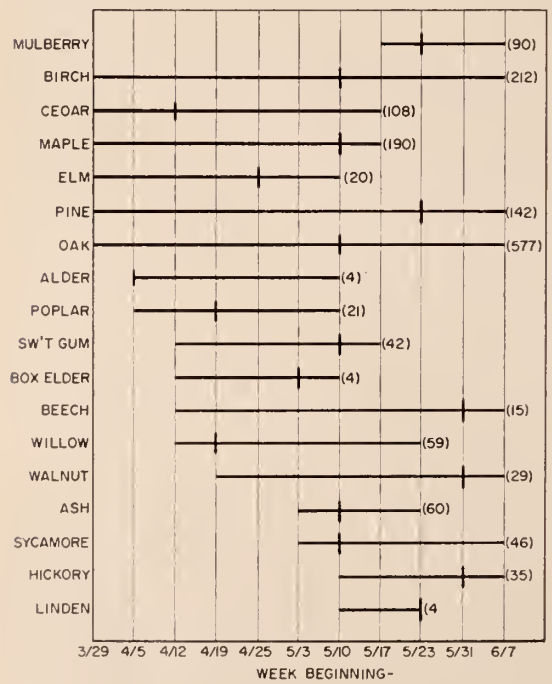


FIGURE 1

POLLEN SEASONS IN N.J.

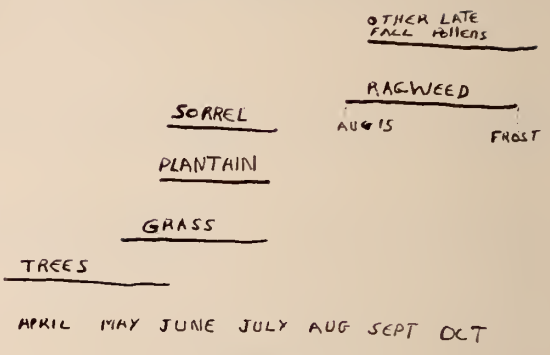


FIGURE 2

The molds are also significant, especially around lakes and swampy areas. They occur in or outdoors and are present all year round except when there is snow on the ground.[14] The spores are present in large numbers in pollen seasons but have a longer season. Most of the spores are not prevalent on rainy days but on dry, windy ones. On such a day, keeping the patient indoors in an air-conditioned room during the early hours is helpful.[15] A specific mold diagnosis can be made by exposing mold plates in the patient's environment and then correlating the specific molds grown with skin tests. The most important molds in this area are Alternaria, Hormodendrum, Cladosporium, Pencillium, Aspergellis, Helminthosporum, Mucor, Fusarium, Rhizopus, and Pullularia.[6]

Different antigens play a role at different ages. The earliest positive skin tests to inhalants were found in farm children who

were exposed to animals. As a child gets a little older, dust and mold play important roles. Pollens, although there are exceptions, are not important until the age of five.[17] Therefore, in a two-year-old, to do a wide survey including many pollens, makes no sense.

Frequently, the allergist is handed results of food testing surveys on patients who had 100 scratch tests done for foods and were told they are allergic to 50 of them. The patient is confused, since many of these are foods never eaten. The routine use of survey food skin tests was given up in 1940 by Dr. Robert Cooke, since many people with positive skin tests to foods had no clinical symptoms from these foods, while some very sensitive patients got anaphylactic reactions when skin tested.[18] The most effective way to make a diagnosis of food allergy is by history, elimination diets, or by food provocation tests. Three types of skin tests are used in this country: intradermals, punctures, and scratch tests, all of which have good and bad points and may prove useful to the individual patient.

Some use the word *hyposensitization* for the treatment that used to be called desensitization, since it is rare completely to desensitize the patient so that he is entirely symptom free. But in most patients, symptoms become less severe. No longer does the allergist have to defend the efficiency of such treatment, since various studies such as the ones by, Sudan,[19] Patterson,[20] and Lichtenstein,[21] have proved their usefulness. The real question is why it works, and for this we have no answer. We know that there are changes made in the leucocytes and in various antibodies in the serum, however, just how these correlate with symptom changes, we are not sure. To obtain good results, it has been shown for ragweed, on which most of the studies have been done, at least 20-30,000 P.N.U.'s per year are necessary.[22] If we accept the same figures for trees, note that if we give 3,000 P.N.U.'s of a 6-tree mixture every four weeks, very little of any specific tree antigen is being given, and the tree antigen injections will not be effective. This is the reason accurate diagnosis is important and use of stock mixtures must be abandoned.

The actual technic of administering the injection is simple. A T.B.C. type syringe with a 26 gauge ⅜″ needle can be used. The extract should be injected midway between the elbow and shoulder perpendicular to the skin surface, subcutaneously.

No dose elevation should be attempted in less than three or more than fourteen days. If the period is 15 to 30 days between injections, the dose should be maintained. A drop of 10 per cent in dose for every week over four between injections is necessary and a call to the allergist is a good idea.

Antihistamines shouldn't be given with or before the injection since they may block the local reaction but not a systemic one. The local reaction is a warning and should be heeded to slow up the dose increase.

If a constitutional reaction occurs, a tourniquet should be placed above the injection site and 0.3 to 0.5 cc 1/1000 aqueous epinephrine given subcutaneously and probably an antihistamine. Steroids have no effect on the immediate life threatening symptoms.

Office spirometry can be helpful in the asthmatic patient. It is not difficult to do nor are the instruments needed expensive. Most children over five will cooperate and good results can be obtained. You will note from Figure 3, the lung can be divided into various compartments. There is first the Tidal Volume (TV) which is the amount of air that is breathed in and out on quiet inspiration. The Inspiratory Capacity (IC) is the amount of air that the patient can breath in at the end of his usual expiration. The Vital Capacity (VC) is the amount of air the patient can breath out after maximum inspiration. The Expiratory Reserve Volume (ERV) is the difference between the Vital Capacity and the Inspiratory Capacity. The Residue Volume (RV) is the amount of air that the patient cannot breathe out, or the amount of the air left in the lungs after the maximal expiration.[23]

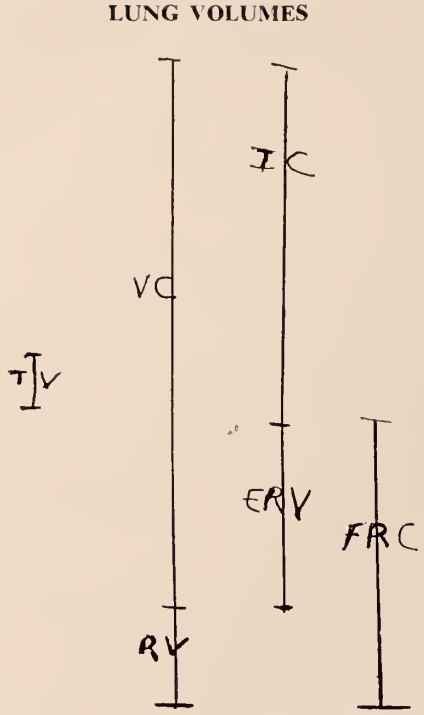


FIGURE 3

In asthma, air is trapped in the lung. The Residue Volume is obviously increased and this is the reason for the increase in the A.P. diameter of the chest and the low diaphragms noted on the x-rays.[24] Measurement of this is not an office procedure.

For the asthmatic, the element of time must be taken into consideration, since the basic defect is obstructive. (Figure 4) Here we are interested in the Forced Vital Capacity (FVC) which is the amount of air that one can force out of the lungs after maximal inspiration. Obviously, the asthmatic cannot, by forced expiration, exhale as much air for a given time as the normal. If we take the percentage of the Forced Vital Capacity he gets out for a given amount of time such as 1 second (FEV1), we will note that the normal person will exhale 75 to 85 per cent of his FVC while the asthmatic will do less.[25] The amount of air exhaled in one second is called the Forced Expiratory Volume in one second (FEV1). Most asthmatics have symptom free periods where the lungs are perfectly clear.

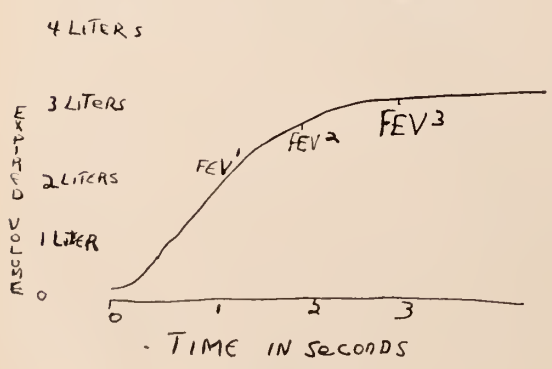


FIGURE 4

However, in some of these patients, if we do pulmonary functions in the supposedly symptom-free periods, we will note an obstructive defect and the x-rays show low diaphragms and increased markings. It is these patients who go on to fibrosis and chronic lung disease. These are the patients who should be treated with the chronic use of oral bronchilators, breathing exercises, and postural drainage. Even though when you ask these children how they feel, the child says, "fine," when they have a small insult to their lungs, they will be in greater distress than the child who starts out by having normal pulmonary functions and therefore more reserve.

I would like to tell you a personal way by which I evaluate my asthmatics. I am interested in three basic facts.

1. What triggers the child and how much exposure does the child have to these triggers?
2. How labile is the child?
3. What is the ordinary state of the bronchial tree?

An example on one end of the spectrum is the child who has normal x-rays, lungs clear on examination with normal spirometry, but who wheezes every time he goes near a dog. He is given epinephrine which usually clears him immediately. This patient is easy and although he looks severely sick on exposure, he has no chronic problem. On the other hand, there is the child with x-ray changes, constant wheezing, obstruction on the spirometry, who has many triggers to his asthma. He does not respond dramatically to any form of treatment and he is the one who needs long-term comprehensive management.

It is good to divide the management of the patient into three phases. The first is avoidance of triggers. By triggers, I do not only mean the dogs but also important are the emotional factors, weather, pollution, and other non-specific triggers. I do not believe that emotional factors are the primary and first triggers of wheezing; however, as the illness becomes chronic, they often are overriding elements in the child's attacks. It is the job of the allergist to find the triggers and try to minimize the patient's exposure to them. Second is the use of drugs such as antihistamines, sympathomimetics and if necessary, in the rare case, steroids. Finally there is specific hyposensitization therapy where avoidance is not possible. Antihistamines are most effective when they are used before the onset of symptoms and they fall into four different pharmacologic classes (Figure 5).

First there are the ethanolamines, such as Benadryl®; second, the ethylenediamines such as Pyribenzamine®; third, the alkylamines such as Chlor-Trimetron®; and finally, the miscellaneous group such as Forhistal® and Periactin.® By picking from different groups and using combinations, you may get relief in the individual patient with fewer side effects. If relief is not obtained by the first antihistamine, switch to an antihistamine from a different group. It also has been noted that the allergic patient may tolerate much larger than the recommended dose of a particular antihistamine.

Exercise may be beneficial to the asthmatic, but exercise-induced asthma is frequent in children. This often can be prevented by prophylactic bronchilators a half hour before the child exerts himself. Many patients are benefited by graded exercise programs which allow the child to accomplish more for a specific energy expenditure. These graded exercise programs, however, will not improve the objective pulmonary functions of the patient.[27] Swimming, bicycle riding, running, and team sports are all excellent. The child who complains of wheezing when he goes out into the cold has a type of asthma mediated

FIGURE 5
Antihistamines*

Groups	Special Characteristics	Generic Name	Trade Name	Tablet Size	Liquid Dose Per 1 tsp.	6-Year-old's Average Dose	Frequency of Dose Per 24 Hrs.	Others
Ethanolamines	"More" drowsiness	Diphenhydramine	Benadryl†	25, 50 mg.	10 mg.	1-2 tsp.	3-4	Clistin, Ambodryl
Ethylenediamines	Good local anesthetic, can cause gastrointestinal upset	Tripelennamine	Pyribenzamine†	25, 50 mg.	20 mg.	1-2 tsp.	3-4	Allercur, Histadyl
Alkylamines	CNS stimulant	Chlorpheniramine	Chlor-trimeton	4, 8, 12 mg.	2 mg.	½-1 tsp.	3-4	Dimetane, Actidil, Polaramine
Cyclizine	Long action, "less" drowsiness	Chlorcyclizine	Perazil	25, 50 mg.	—	½-1 tsp.	2	Hispril
Phenothiazines	"More" drowsiness	Promethazine	Phenergan	12.5, 25 mg.	6.25 mg.	1-2 tsp.	1-3	Tacaryl, Theralistin
Miscellaneous		Phenindamine	Thephorin	10, 50 mg.	10 mg.	1 tsp.	1-3	
		Dimethpyrindene	Forhistal	1, 2.5 mg.	1 mg.	1-2 tsp.	1-3	
	Antiserotonin and antihistamine	Cyproheptadine	Periactin	4 mg.	2 mg.	1-2 tsp.	3	

* The *usual* dose for *most* antihistamines is about 1 tsp. for a 6-year-old, ½ tsp. for a 3-year-old, three or four times daily; 12-year-olds use adult dosages. The dosage can safely be increased if it does not cause sedation or undesirable side effects.[34] Children can frequently tolerate higher doses than adults.
†2 to 4 mg. per lb. per day[31] or 30 mg. per square meter four times a day.

by the parasympathetic system and very often can be helped by giving prophylactic atropine.

The ephedrine-xanthine oral combinations, such as Tedral® and Marax,® are the usual bronchodilators. One tablet of Tedral® equals one of Marax.® But, two teaspoons of Tedral® equals one tablet, while four teaspoons of Marax® equals one tablet of Marax.® The flavoring in Tedral® is licorice which is a legume as are peanuts. If the patient is allergic to peanuts,[28] don't use liquid Tedral.®

Steroids are often the difference between life and death in the hospitalized asthmatic. But in children their use for most attacks (or on a long-term basis) is rarely justified. Rather than using steroids in the acute asthmatic attack, most of us would rather put the child in the hospital for two or three days on conservative management, if outpatient therapy does not work. The way steroids are given is important. For the acute, seriously ill patient, intravenous is the preferred route. For the patient on chronic steroids, Prednisone® given, if possible, every other morning, has been shown to have the fewest side effects on the adrenals. The intramuscular use of Deprol® must be condemned since it has a severe effect on the adrenal-pituitary axis.[29]

We are constantly asked if the child will "grow out" of his allergies. The allergic state is a life-long illness. Most asthmatics will have symptom-free periods which may occur anytime in life for no specific reason. The specific allergic triggers may also change, as may the type of symptoms. I often see adults who have had asthma as children and had symptom-free periods in their teens, who return at the age of 30 or 40 with hayfever. Of course, I only see those patients who have symptoms again and never see the ones that remain symptom-free.

The eosinophil is not specific for the allergic inflammatory reaction.[30] These are phagacytic cells common to all inflammatory reactions regardless of etiology. They are especially seen in the recovery phase of inflammation. In the peripheral blood they vary widely in time. They will be highest in the morning before endogenous steroids and cathacholamines lower them. Their presence does not make the diagnosis of allergy. In fact, if you get any eosinophil count which is above 10 per cent I would look for causes other than allergies to explain the eosinophils. Nasal smears for eosinophils have often been used as diagnostic of allergies, but they are non-specific. Eosinophils are the most common cell in nasal secretions in children under six months of age and the study done in Vancouver[31] showed that they have no diagnostic significance in the older child for allergy.

We allergists welcome the pediatrician or family doctor who wishes to take over the every day management of the patient. However, this may cause a problem of communication even though it makes it convenient and cheaper for the patient. Often the child is given the injection by the nurses without the doctors examining him. This may be adequate for the rhinitis patient but not for the asthmatic. Every patient who has asthma should be examined before the injections are given since even though the patient says he is symptom free, wheezes are often noted. These are the patients who should be on chronic medication and if the general practitioner or pediatrician finds this to be the case, a simple phone call to the allergist is usually appreciated by all concerned. Most general practitioners and pediatricians are willing to turn the care of these patients (who pose severe problems) over to the allergist for daily management.

In the usual, suburban, middle-class practice that many of us are exposed to, most of our childhood asthmatics do very well, having minor attacks with very little loss of school days, by the simple measures that we have previously advocated. The patients who are going to get into trouble usually all do it at the same time. Asthmatics are going to wheeze at the times of the changing seasons—April and May, October and November. The child who

is actually allergic and does not do well on desensitization is extremely rare, and, therefore, in the long run, the use of Intal® will find only a small place in our drug armamentarium. The patient who wheezes at times when your other patients are not wheezing, should stick out to the physician like a red flag. Look for something else—the hidden allergen, or the family's emotional make-up. More often than not, your probing will come up with something that previously was unexpected, and the patient will run a much smoother course.

A bibliographic listing of 31 citations is available from the author.

330 Ratzer Road

Medicaid Policy

Claims for medical expenses covered under an applicable "No-Fault" insurance policy will not be reimbursable by the Medicaid Program. This will apply to all claims submitted for payment to the appropriate Contractors after June 1, 1973, as well as all claims previously submitted but not yet paid as of that date, which arose out of covered accidents which occurred after January 1, 1973.

All providers affected by this policy are directed to determine whether the injuries involved were caused by an automobile accident for which there is "No-Fault" insurance coverage. If it is determined that "No-Fault" insurance coverage exists, providers are directed to seek reimbursement from the recipient's "No-Fault" insurance carrier or from the recipient himself (if payment has been made to him), and not from the Medicaid Program.

Providers must indicate on their claim forms whether or not the injuries involved arose out of an automobile accident. On those claim forms for which there is no specific question regarding whether the injuries arose out of an automobile accident, e.g., Hospital Claims, this information must be provided in the "Remarks" box. The statement "Auto Accident—Yes" or "Auto Accident—No" will suffice. Providers must also indicate whether there is "No-Fault" coverage in the particular case. Claim forms which fail to supply this information may be delayed or returned to the providers for additional information.

Forms which indicate that the injuries involved arose out of an automobile accident must contain certain additional information regarding the "No-Fault" status. Providers who receive "No-Fault" payments for care, services, or supplies which are less than the provider would have obtained under the Medicaid Program may submit claims for the difference between the "No-Fault" payment and the Medicaid payment to the Contractor with an explanation from the "No-Fault" carrier of the amount of money obtained from the proceeds of the "No-Fault" insurance policy. Providers furnishing services or supplies to recipients injured in accidents which are not covered by an applicable "No-Fault" insurance policy, (or for which payment has been denied by the "No-Fault" carrier) may submit their claims to the Medicaid Contractor with a letter denying payment.

Doctors who already have been reimbursed by the Medicaid Program for claims arising out of covered automobile accidents occurring after January 1, 1973, should reimburse the Medicaid Program as soon as possible after "No-Fault" payments have been received.

Reimbursement to the Medicaid Program resulting from "No-Fault" payments is to be made payable to the "Treasurer, State of New Jersey" and mailed to: State of New Jersey, Division of Medical Assistance and Health Services, Bureau of Medical Care Surveillance, P.O. Box 2486, Trenton, New Jersey.



Everybody experiences psychic tension.



Most people can handle this tension.



Some people develop excessive psychic tension and need your counseling,



and a few may need counseling
and the psychotropic action of Valium® (diazepam).

Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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Lead poisoning in young children is easily missed. Here are some words to the wise.

Acute Lead Intoxication

Herbert F. Hein, M.D. and Irving H. Plain, M.D./Newark

Lead poisoning in children is one of the major medical problems of our time. The physician primarily involved in the treatment of this disorder is the pediatrician, since the younger age group is the one most often afflicted. However, very often the ophthalmologist is consulted and asked to aid in treatment when ophthalmic sequelae appear.

Most frequently, the presenting symptoms of systemic lead poisoning are referable to the central nervous system. It is not uncommon for medical aid to be sought only after convulsions or delirium make their appearance.[1] Occasionally, eye signs appear early in the course of the intoxication, and in some cases even as one of the presenting signs. The following case illustrates this point:

A one-year old child was admitted to St. James Hospital on September 9, 1971, with the following signs: temperature of 102°, vomiting, seizures, and malaise. The factor which motivated the mother to bring him to the pediatrician was sudden marked esotropia. Systemic lead poisoning was suspected. There was a history of pica.

Admitting serum lead level was 200 mgms per cent, (normal value 0 to 60 mgms per cent).[2] X-ray studies revealed increased densities of the epiphyseal plates of the knee joints, distal radii, and ulnae.

Calcium versanate therapy was begun immediately along with supportive measures to control any further convulsions.

Eleven days following admission, serum lead level had decreased to 87 mgms per cent. Electroencephalogram showed an abnormally slow record. Ophthalmologic consultation revealed an alternating esotropia of 45 prism diopters. Pupils reacted sluggishly to light. The optic nerve heads appeared pale but were felt to be within normal limits. No ophthalmologic therapy was given, since the eye findings were believed to be related to the systemic lead poisoning.

In addition to the four courses of versanate, whole blood was administered because of the anemia which had been produced by the lead intoxication. Eventually, the blood level was reduced to 65 mgms per cent. The hospital course was marked by spiking temperatures and generalized seizures. Eye examination just prior to discharge showed no evidence of any eso-deviation or pupillary abnormalities.

It is unusual but not unknown for lead poisoning to start with ophthalmologic manifestations. Several cases have been reported where parents had become aware of the intoxication and sought medical aid for the affected child because of the presence of an internal squint.[3] The eyes may also be secondarily involved in systemic lead poisoning. Baghdassarian[4] reported optic neuritis as the most common visual disturbance associated with systemic lead poisoning intoxication. Optic atrophy may result.

Lead most commonly enters the body through the alimentary tract and is most frequently encountered in children with pica. However, even the drinking of tap water which has been conveyed through heavily laden lead pipes can cause elevated lead levels. The burning of lead storage batteries as a heat source by low-income families, with subsequent inhalation of the noxious fumes, provides another lead hazard.[5] Insecticides comprised of lead compounds heavily sprayed on fruits and vegetables can also lead to systemic intoxication.[6]

Calcium sodium versanate in the treatment of lead intoxication has saved many lives, both young and old, and has reduced the morbidity of this devastating condition.[7] However. no therapeutic agent will ever be as effective as the prevention of the disorder. Cure of this disease lies in its prevention through careful education of the public as well as environmental controls. Until these steps are taken, lead poisoning will continue to be one of the leading environmental diseases of the inner

cities, and helpless children will be its chief victims.

The authors wish to express their thanks to Nathan Zukerberg, M.D., Chief of Pediatrics, St. James Hospital, Newark, New Jersey, for his kind assistance.

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Overprescribing of Antibiotics

The director of the Federal Drug Administration's Bureau of Drugs has charged before a Senate subcommittee that physicians are overprescribing antibiotics, resulting in an increased number of "resistant strains of bacteria and an increased number of superinfections."

"There may be 100 to 300 thousand cases each year of blood poisoning from superinfections, of which 30 to 50 per cent are fatal," according to testimony before the Senate Small Business' Subcommittee by Henry E. Simmons, M.D.

Harry F. Dowling, M.D., emeritus professor of medicine, University of Illinois, said "It is doubtful the average person has an illness that requires treatment with an antibiotic more often than once every five or ten years." Antibiotic production has needlessly increased, however, in the past ten years, he said.

The physician's fear of failure to help his patients—stronger than his fear of complications—motivates him to prescribe antibiotics, suggested Calvin M. Kunin, M.D., of the University of Wisconsin School of Medicine.

Medical Meetings on Tape

The American Medical Association has inaugurated for its membership an audio cassette tape service through which highlights of AMA meetings, symposia, and conferences are summarized. Each tape plays one hour. Now available are:

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National Conference on Rural Health

National Congress on the Socio-Economics of Health Care

The tapes may be purchased at $5 each. Address orders to Department of Radio-TV-Film, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610

A physician's responsibility to his disabled patient includes his furnishing evidence needed by Social Security to enable him to get the monetary benefits to which he may be entitled.

Special Article

Disability Insurance Under Social Security

Eric H. Wolf, M.D., Newark*

Whenever you are asked to furnish a report in connection with a patient's claim for social security disability benefits, it's a reminder that social security is not just for the retired. It also provides financial help for people who cannot work because of a serious illness or injury. Currently, over 3 million men, women, and children receive social security disability checks every month because someone in the family—usually the breadwinner—is disabled. Their payments total almost $5 billion a year. In addition, more than 76 million working men and women are insured under social security for disability benefits as a result of their earnings—wages or self-employment. Beginning July 1, 1973, full Medicare protection was extended to persons under age 65 who for at least 24 consecutive months have been receiving monthly social security benefits because they are disabled.

A person under 65 can receive monthly disability if he has a physical or mental impairment severe enough to prevent him from doing any substantial gainful work for a year or longer. Benefit amounts based upon earnings under social security range from $84.50 to $345.50 a month for the disabled worker alone. Maximum monthly benefit for a disabled worker with a family is $620.40.

Everyone who applies for disability benefits—whether he subsequently receives monthly benefits or not—is screened for possible services by the Division of Vocational Rehabilitation. Such services include counseling, teaching new employment skills, training in the use of prostheses, and job placement. These services are generally provided from State-Federal appropriations. In some cases, however, social security pays the cost of rehabilitating disabled beneficiaries.

The original Social Security Act of 1935 provided benefits only for the retired worker. It was not until 1954, when the disability "freeze" provision was added, that the law gave some protection to the disabled worker. Thus the years when a worker earned little or nothing because of disability were not counted against him later in deciding if he was eligible for retirement benefits, or in figuring his retirement benefit amount. Later, monthly cash benefits were provided for disabled workers aged 50 to 64, and also for the disabled adult sons and daughters of retired or deceased workers if the son or daughter had been continuously disabled since childhood.

Over the years, the program has been further improved. The minimum age limit of 50 for payment of benefits to disabled workers was eliminated; "long-continued and indefinite" duration was changed so that an insured worker could be eligible if his disability had lasted or could be expected to last 12 months; fewer years of covered employment were required for a young worker to be insured for disability; and benefits were provided for disabled widows (between ages 50 and 60) of covered wage earners. The latest change is Medicare protection for disabled persons under 65.

Who Can Get Benefits?

Social Security disability benefits can now be paid to:

*Dr. Wolf is Medical Director of the Division of Disability Determinations, New Jersey Department of Labor and Industry, 1100 Raymond Boulevard, Newark, New Jersey 07102.

1. *A disabled worker* under 65 and his family, if he has worked under social security for a certain length of time, ordinarily 5 or 10 years preceding the onset of disability. (Special provisions apply to workers disabled by blindness allowing them to qualify with even less work under the program.) For the worker who becomes disabled before he reaches 31, the work requirement ranges down with age to as little as 1½ years.

2. *A person continuously disabled since childhood* (before age 22), if one of his parents (in some cases a grandparent) who is covered under social security retires, becomes disabled, or dies. The mother of the disabled son or daughter may also receive monthly benefits as long as she has the child in her care.

3. *A disabled widow 50 or over,* if her late husband was covered under social security, and if she meets the specified level of medical severity. This also applies to disabled dependent widowers and certain disabled surviving divorced wives.

Medical Evidence

When a patient applies for benefits, he is asked to submit medical evidence to support his claim. This usually consists of data from the records of his treating physician, clinic, or other medical source. Our experience indicates that in about three out of five cases no further medical development is needed because the treating source already has enough information on record to provide a good picture of the applicant's condition and how it limits his ability to work. This information may be requested on the patient's behalf by a social security office—or, more often, by the Division of Disability Determinations. This is the full name of the agency in New Jersey that evaluates social security disability claims for New Jersey residents. Like other State agencies throughout the country that work with social security in the disability insurance program, the Division of Disability Determinations in New Jersey includes both physicians and trained disability examiners on its professional staff. They form a balanced team of medical and non-medical people who can handle anything from a strictly medical issue to a complete assessment of the vocational factors which bear on the disability decision.

With the assistance of our staff of reviewing physicians, we make these requests for medical information relate as directly as possible to the condition which the claimant states is the cause of his disability. The goal of the individually tailored request is to ease the medical reporting burden of the busy physician or clinic, without jeopardizing the claimant's right to have his case decided on the basis of *all* relevant information available.

The evaluating physician in New Jersey never sees the patient. He depends heavily on information supplied by the physician or clinic to assess the severity of the applicant's impairment, its expected duration, and the extent of his residual functional capacity. The disability decision, therefore, rests largely on the quality of the medical evidence obtained. A detailed report from the treating source, including objective findings and laboratory procedures, will usually be sufficient to enable us to evaluate the claim and make a decision.

For example, if the patient experienced a myocardial infarction, we would look to the report submitted by the treating source for such information as date of occurrence, place and duration of the hospitalization, as well as results of x-rays, electrocardiograms, and other laboratory studies. Serial EKG tracings should, whenever possible, accompany the report so that our physicians may have the benefit of reviewing this essential documentation. Equally important is the medical history, including onset of chest discomfort, relationship to effort, intensity, location, radiation, regularity, and to what extent relief is obtained by rest or medication.

If a report does not contain all the findings necessary to make a proper decision, one of our reviewing physicians may make contact with the medical source. However, the additional time thus required may delay the patient's claim and can add up to a significant additional program expense. You can help speed the decision on your patient's claim by reporting all relevant data about his medical condition as promptly as possible.

Establishing the onset date of disability—often a key factor in determining the beginning date and amount of the claimant's ben-

efits—is frequently difficult. Therefore, it is helpful if the reporting physician includes the date of each important fact or finding. To save time, he may enclose photocopies of pertinent sections of the patient's chart or of hospital or consultant's reports.

Criteria of Disability

In making disability determinations, our agency uses medical criteria developed by the Social Security Administration to insure uniform evaluation of all applicants no matter where they live, and to simplify and speed the decision process. These criteria were worked out with the aid of practicing physicians, major medical organizations, and SSA's Medical Advisory Committee.

Generally, a claimant who is not working can meet the social security definition of disability if he has an impairment or combination of impairments that are the same as, or medically equivalent to, any set of findings in the criteria. (This is the only way the widow 50 or over can qualify for disability benefits.) However, for *all other claimants* whose impairments fall short of this test, such factors as age, education, and work experience added to the functional limitations imposed by the medical condition are taken into consideration in making the disability decision.

The complete criteria, including the medical findings listed by body system, are contained in a handbook designed especially for professionals who come in contact with the disabled population. The handbook describes impairments in terms of specific symptoms, signs, and laboratory findings that are presumed to be severe enough to prevent a person from working for a year or longer.

The handbook may be obtained from Division of Disability Determinations, 1100 Raymond Boulevard, Room 302, Newark, New Jersey 07102. We also welcome any inquiries from physicians who wish to know more about the social security disability program.

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As with the other specialty programs, the psychiatry series will be issued twice each month. Each tape is one hour in length. Editorial contents consist primarily of on-the-spot recording, from principal national specialty meetings, as well as condensations of recordings direct from graduate courses.

Our editorial staff does extensive scanning of 60 medical journals and records more than 200 national meetings throughout the year. Then, in an hour of easy, informative, practical, useful listening, they pass on to the subscriber all that is new and important in his ever-changing clinical practice picture. Doctors interested in becoming charter subscribers should indicate their intention by writing Mr. Claron L. Oakley, Audio-Digest Foundation, 1930 Wilshire Boulevard, Los Angeles, California 90057, for order forms and information.

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Plasma Testosterone as a Diagnostic Aid in Adult Women

Although controversy still persists as to the clinical value of plasma versus urinary androgen assays, the consensus is that free hormone levels in plasma more closely reflect the physiological effects at the target tissues. As with other hormones, the testosterone level in plasma reflects a result of alterations of both the production rate and the metabolic clearance rate.

The advent of new assay technics has enabled the laboratory to measure with accuracy and specificity the low levels of testosterone found in women and prepubertal children. The competitive protein-binding method we formerly used, published by the Research Staff at Bio-Science[1], was recently superseded by a new radioimmunoassay procedure[2] with significantly greater sensitivity.

The range of plasma testosterone in normal adult females extends from 30 to 95 nanograms/100 ml. (1 ng = .001 microgram). Although there is no evidence of a diurnal variation in women, plasma levels are higher during the ovulatory and luteal phases of the cycle. During pregnancy the concentration increases significantly but has no relationship to the sex of the fetus.

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Levels were found to be above normal (100-300 ng/100 ml.) in one study[3]. ACTH or glucocorticoid administration resulted in a drop in testosterone levels[4].

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Plasma testosterone levels in these cases range from 30 to 300 ng/100 ml. Variable effects on the testosterone levels have been reported following ACTH, HCG and FSH administration. Synthetic glucocorticoid or estrogen-progesterone combinations reduce elevated levels to the normal range[3,5].

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Arrhenoblastomas, dermoids, malignant teratomas and possibly other tumors may secrete testosterone.

Specimen Required:

2 ml. serum or plasma. Specimens are stable without refrigeration or preservative for 7 days.

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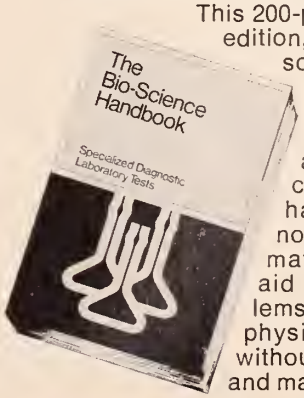
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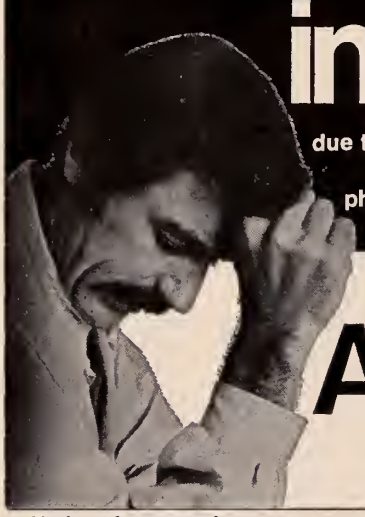
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Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinued as soon as hypercalcemia is detected.

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NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

July 15, 1973

A regular meeting of the Board of Trustees was held on July 15, 1973, at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

Pre-College Conference on Health Professions . . . Approved the following recommendations from the July 11th meeting of the Executive Committee:

1. That MSNJ support the Pre-College Conference on Health Professions and underwrite expenses up to $400, provided MSNJ is given recognition as a co-sponsor.

Note: Purpose of the conference, which has been arranged by Rider College (Trenton) and will be held there on November 10, is to make available to students the facts regarding medical school study and admission and to emphasize related areas of study which are becoming increasingly important in the medical field.

2. That the Board of Trustees urge the Committee on Medical Education to encourage the concept of regional programs on the health professions at the high school and college levels.

Health Care Administration Board . . . Authorized James A. Rogers, M.D., to represent MSNJ at a meeting of the special subcommittee of the Health Care Administration Board which is concerned with clarification of the language cited in the law (C. 136 and 137, PL of NJ, 1971) as it pertains to the private practice of medicine.

Annual Meeting . . . Approved the following recommendation from the Committee on Annual Meeting:

1. That in January 1974, personal letters be sent to all members (1) reminding them of the upcoming annual meeting, (2) inviting them to attend the sessions of the House of Delegates and reference committee meetings, (3) enclosing a hotel reservation form and details of proposed activities for a "package-deal" weekend, and (4) stressing the importance of every-member-registration.

2. That GMA recipients and their families be invited to attend the election session of the House (Bylaws, Chapter IV, House of Delegates, Section 1, Meetings)

3. That $100 honoraria be presented to guest speakers participating in the scientific sessions, and that there be a maximum of three guest speakers per single or joint session.

4. That official delegates (from other State Societies) be introduced and allowed time for a brief message at any one session of the House.

5. That Secrephone be engaged for reporting future sessions of the House of Delegates and the dinner-dance.

6. That SAMA representatives from the two New Jersey medical schools be invited to attend, as observers, the 208th Annual Meeting, with expenses paid up to $150 per student.

. . . Directed that the Standing Committee on Medical Education designate a specific number of credit hours to those physicians who attend the annual meeting.

Medical Defense and Insurance . . . Approved the following recommendations from the Committee on Medical Defense and Insurance:

1. That the Board of Trustees of MSNJ inform the E. & W. Blanksteen Agency to notify the Automobile Insurance Company of Hartford to extend coverage to members of the Woman's Auxiliary of MSNJ who apply for insurance.

2. That the Board of Trustees approve the procedure of authorizing the Committee (on Medical Defense and Insurance) to meet with the State Commissioner of Insurance for discussion of specific insurance matters related to MSNJ's malpractice program, when indicated.

3. That in order for health maintenance organizations to be insured for professional liability by the Joseph A. Britton Agency, *all* eligible participating physicians must be members of MSNJ.

MSNJ Endorsement of Medicredit . . . Approved the following resolution for submission to the AMA and directed that a copy, as well as a synopsis of the Medicredit bill, be sent to each member of the New Jersey Senate and General Assembly:

Whereas, legislation proposing a program designated as "Medicredit" has been introduced into the 93rd U. S. Congress; and

Whereas, Medicredit is a program of providing health insurance protection which would pay the full cost of

health insurance for those too poor to buy their own; and

Whereas, Medicredit would help those who can afford to pay part of their health insurance costs in accordance with their ability to pay; and

Whereas, Medicredit would assure that no American would have to bankrupt himself because of catastrophic illness; now therefore be it

RESOLVED, that The Medical Society of New Jersey endorse the legislative philosophy providing for the Medicredit Program; and be it further

RESOLVED, that a copy of this resolution be sent to both U. S. Senators from New Jersey and all New Jersey members of the U. S. House of Representatives.

New Jersey Foundation for Health Care Evaluation . . . Directed that the Core Committee of the New Jersey Foundation for Health Care Evaluation be discharged, with commendation for a job well done.

Carrier Clinic Annual Symposium . . . Agreed to grant use of the Society's name as a cooperating agency in the Carrier Clinic's presentation of the forthcoming symposium on "Human Sexuality Today," to be held at the Clinic on October 3.

Multiple Risk Factor Intervention Trial-Clinical Center . . . Agreed to supply a letter of endorsement relative to the application of CMDNJ—Rutgers Medical School to compete for a Federal contract called Multiple Risk Factor Intervention Trial-Clinical Center, sponsored by the National Heart and Lung Institute, the purpose of which is to analyze data, in combination with data collected by at least ten other similar centers in the country, on people who are considered high risk for coronary heart disease to determine whether treatment of the risk factors is feasible and, if so, whether it reduces the risk of premature morbidity and mortality from coronary heart disease.

Joint Commission on Accreditation of Hospitals TAP (Trustees, Administrators, Physicians) Institute . . . Agreed to cosponsor, with the New Jersey Hospital Association, the above-named Institute, which is designed to help participants implement effective hospital internal quality control programs required by the revised JCAH Accreditation Standards.

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President, CMDNJ

Since its inception in 1970, the College of Medicine and Dentistry of New Jersey has placed high priority on the continuing development of high-quality teaching programs.

During the past three years, student enrollment at the College's Rutgers Medical School has increased nearly eight-fold. Sixteen students were enrolled in the first-year class and sixteen in the second-year in 1970. In September, 1971, under the leadership of Dean James W. Mackenzie, M.D., the first-year class was increased to 80 and last September the first-year class grew to 88.

Last September CMDNJ-Rutgers Medical School also passed a milestone in its development from a two-year school to a four-year M.D. degree-granting institution by matriculating its first third-year class of 32 students. This year those 32 students become the first fourth-year class and next June they will become the first to receive their M.D.'s from CMDNJ-Rutgers Medical School. This fall, CMDNJ-Rutgers Medical School is also enrolling 32 third-year students, 88 second-year students, and 93 in the first-year class.

Third-year clerkships at CMDNJ-Rutgers Medical School are scheduled in four periods of eleven weeks each in medicine, obstetrics-gynecology-pediatrics, psychiatry-neurology-ophthamology, and surgery-anesthesiology subspecialties.

The flexible fourth-year curriculum is divided into ten four-week periods beginning in August and ending in May. Up to eight weeks may be used as vacation, either in a single block or subdivided in a way most convenient for the student. The remaining thirty-two weeks must be spent in approved educational activities selected by the student with the advice of a faculty counsellor.

All fourth-year students will be required to study family medicine. The rest of the stu-

dent's program will be tailored to meet his or her particular needs. Because of the large number of hospitals affiliated with the school there will be a wide range of programs from which the fourth-year students can choose.

More than one hundred elective courses in central New Jersey hospitals have been proposed by the clinical departments. These will last either four or eight weeks and will be conducted either by the faculty or by other physicians and health professionals under their supervision. They will include advanced clerkships in affiliated hospitals, modified preceptorships with practicing physicians, subspecialty work on a full-time or part-time basis, research projects in clinical fields, and the delivery of health services in urban slums or rural outposts.

Two dozen elective programs have been developed by the basic science departments. These will include opportunities for full-time research projects. Students will be encouraged to take elective courses offered by other medical schools and students from other medical schools are welcome to take the electives offered by CMDNJ-Rutgers Medical School as long as this does not interfere with the education of our own students.

The school is also encouraging its students to work out their own new and different elective programs to meet their individual needs. These programs may be unrelated to any educational institution in this country or abroad. However, they must be judged to be of educational value by the student's advisor and by the chairman of the appropriate department.

Under the direction of its chairman, Frank C. Snope, M.D., the department of family medicine will be organized during 1973-1974. Goals of the department will be to introduce the student to the work of the family doctor and to develop an undergraduate teaching program in family medicine. During their clerkship in family medicine all fourth-year students will be placed in the office of a family physician in the central New Jersey area for a four-week period. The clerkship is designed to acquaint the student with the work of the family physician, to provide the student with an appreciation of the bulk of illnesses which are managed without hospitalization and to demonstrate to the student effective utilization of the community hospital by the family physician. Students will be expected not only to observe the family doctor but also to participate actively in the management of selected families.

Some of the fourth-year students may enter the residency programs currently being developed by CMDNJ-Rutgers Medical School when they graduate next June. It has been noted that doctors tend to remain in the area where they do their residencies. Hopefully all CMDNJ residency programs will not only help to keep our graduates in New Jersey but will also attract graduates from out of state as well.

Testimonial Dinner for Richard I. Nevin

A testimonial dinner-dance honoring Richard I. Nevin, Executive Director Emeritus of The Medical Society of New Jersey, will be held on Sunday, September 16, at the Greenbrier Restaurant, North Brunswick at 6:15 p.m. Invitations have been extended to members of the Medical Society and other interested persons. Reservations may be made by calling Mr. Robert H. Lambert at the executive offices in Trenton, (609) 394-3154. Tickets are $25 each.

Therapeutic Drug Information Center

The New Jersey Regional Pharmaceutic and Therapeutic Drug Information Center, located at the Valley Hospital, Ridgewood, New Jersey, serves as a source of information on specific problems, articles, and reports concerning pharmaceutic and therapeutic information. A specialized library maintained by the Center contains complete information about U.S., foreign, investigational, and proprietary drugs, including their identification, availability, interactions, compatibility, side effects, dosage, adverse reactions and so on.

The Center is staffed by trained pharmacists. Jack M. Rosenberg, Pharm. D., Associate Professor of Pharmacy and Director of Drug Information, Brooklyn College of Pharmacy, LIU, serves as Consultant Director. Salvatore Peritore, M.S., serves as Project Director, and Kenneth Anderson, Assistant Project Director. The service is provided free, open seven days a week, and is available by telephone—(201) 445-4900, extension 304. To date, over 2,000 questions have been received by the Center, the majority from physicians. Below are three questions and answers handled by the Center recently.

1. Should the dose of reserpine be reduced in patients with renal failure?

In a study by Zsoter, *et al.*[1] it is stated, "We found no evidence of adverse effects from reserpine in patients with the lowest creatinine clearance. This is consistent with the clinical impression that the dose of reserpine does not have to be reduced in such patients." Reserpine is extensively metabolized and less than one per cent of injected reserpine is excreted unmetabolized in the urine. The metabolism of reserpine does not appear to be altered by renal failure.

[1]Zsoter, T. T., *et al.: Clin. Pharmacol Ther.*, 14:325 (May-June) 1973.

2. Are there any reports of tumor induction in humans from parenteral iron therapy?

The possible hazard of tumor induction by iron dextran injection (Imferon®) has been discussed often in the past and was reviewed by Roe.[1, 2] In animals local tumors have been induced by iron dextran injection.[3, 4]

MacKinnon and Bancewicz[5] reported two cases of sarcomas in humans arising at the site of previous iron dextran injections. One of the tumors showed a histologic pattern associated with iron dextran administration in animal experiments.

[1]Roe, F. J. C.: In *Potential Carcinogenic Hazards from Drugs*, ed. Rene Truhaut. Berlin, Springer-Verlag, 1967

[2]Roe, F. J. C. and Carter R. L.: *Int. J. Cancer*, 2:370 (1967)

[3]Goldberg, L., Martin, L. E., and Smith, J. P.: *Toxicol Appl. Pharmacol*, 2:683 (1960)

[4]Fielding, J.: *Br. Med. J.*, 1:1800 (1962)

[5]MacKinnon, A. E. and Bancewicz, J.: *Br. Med. J.*, 2:277 (1973)

3. Do you have any reports of the association between androgenic-anabolic steroid therapy and hepatocellular carcinoma?

Johnson, *et al.*[1] and Bernstein, *et al.*[2] have reported an association between the long-term use of C_{17}-alkylated androgenic-anabolic steroids* and the development of hepatocellular carcinoma.

Henderson, *et al.*[3] recently reported suspected hepatocellular carcinoma associated with androgenic-anabolic steroids.

Johnson, *et al.*[1] concluded that further investigation of the hepatotoxicity of these steroids is required, particularly as used on a long-term basis by athletes to improve muscle development.

[1]Johnson F. L., *et. al.: Lancet*, 2:1273 (1972)

[2]Bernstein, M. S., Hunter, R. L., and Yachmin, S.: *New Engl. J. Med.*, 284:1135 (1971)

[3]Henderson, J. T. and Richmond, J.: *Lancet*, 2:934 (1973)

*The C_{17}-alkylated androgenic steroids in common use are as follows: ethylestrenol (Maxibolin®), fluoxymesterone (Halotestin®, Ora-Testryl®, Ultandren®), methandrostenolone (Dianabol®), methyltestosterone (Metandren®, Neo-Hombreol®, Oreton Methyl®), oxandrolone (Anavar®), oxymetholone (Adroyd®, Anadrol®), and stanolzolol (Winstrol®).

PATRONIZE OUR ADVERTISERS

Communicable Diseases in New Jersey

The following communicable diseases were reported to the Division of Laboratories and Epidemiology during May and June 1973:

	1973 May	1972 May
Aseptic Meningitis	3	16
Primary Encephalitis	2	0
Hepatitis: Total	187	308
Infectious	155	234
Serum	32	74
Malaria: Total	1	1
Military	0	0
Civilian	1	1
Meningococcal Meningitis	3	3
Mumps	199	44
German Measles	808	329
Measles	102	24
Salmonella	75	177
Shigella	48	60

	1973 June	1972 June
Aseptic Meningitis	3	15
Primary Encephalitis	2	9
Hepatitis: Total	223	356
Infectious	169	224
Serum	54	132
Malaria: Total	1	3
Military	0	2
Civilian	1	1
Meningococcal Meningitis	5	2
Mumps	224	88
German Measles	350	233
Measles	96	9
Salmonella	71	110
Shigella	45	13

Animal Bites

During the summer, the New Jersey State Department of Health receives many calls about the handling of people bitten by animals. Under our new policy, no State-supplied rabies vaccine or anti-rabies serum can be released until a physician from the State Department of Health is first consulted. This is done so that there is assurance that the attending physician is familiar with the recommendations of the State Department of Health concerning rabies prophylaxis following animal bites.

With the exception of bats, *there has not even been the suspicion of a rabid animal in New Jersey in almost a decade.* In bites from animals other than bats, where the animal is not available for examination and the bite was provoked, we generally recommend no specific rabies prophylaxis. With bat bites (since the incidence of rabies is so high in biting-bats) some type of rabies prophylaxis is recommended, if a definite bite has occurred. Rabies prophylaxis following encounter with a bat is not recommended if the encounter did not include a bite or a suspicion of a bite.

If an animal is available for examination, decisions as to whether to institute rabies prophylaxis, and the type of prophylaxis to use, are influenced by the results of laboratory examination. Fluorescent antibody technics are used in examination of the brain of the animal. Results are available within several hours after receipt of the specimen in the laboratory. Wild animals involved in a human bite should be delivered to the laboratory of the State Department of Health in Trenton as soon as possible, so that examination can be performed and guidance given as to rabies prophylaxis. The laboratory will receive specimens seven days a week, at all hours of the day or night.

When faced with an animal bite, physicians should give local treatment which involves thorough cleansing of the wound. He should ascertain in as much detail as possible the circumstances surrounding the bite, particularly whether the bite might have been provoked. If an animal is available for examination, it should be immediately taken to the laboratory of the State Department of Health in Trenton. The State Department of Health is available for consultation about animal bites at all times. During normal working hours, we can be reached at 609-292-7300. At all other times, we can be reached through our answering service at 609-392-2020.

If rabies prophylaxis is to be instituted, it must be done as soon as possible. It is important that there be no delay in submitting an animal for examination, in giving immediate local treatment to the wound, and in instituting specific prophylaxis if it is so indicated.

Medicaid Exclusions

Medicaid payment is *not* made for:

1. Any service, admission or item which is not medically required for diagnosis or treatment of a disease, injury, or condition;

2. Any services or items furnished in connection with elective cosmetic procedures;

Note: There are certain exceptions. A certification of medical necessity and a treatment plan must be submitted by the practitioner to the local Medical Assistance Unit, and prior authorization is required. See list of Medical Assistance offices below.

3. Private duty nursing service;

4. Services or items furnished for any sickness or injury occurring while the covered person is on active duty in the military;

5. Services or items furnished for any condition or accidental injury arising out of and in the course of employment, for which any benefits are available under the provisions of any Workmen's Compensation Law, Temporary Disability Benefits Law, Occupational Disease Law, or similar legislation, whether or not the covered person claims or receives benefits thereunder, and whether or not any recovery is had against a third party for resulting damages;

6. That part of any benefits which are covered or payable under any health, accident, or other insurance policy (including any benefits payable under the "Automobile Reparation Act," (P.L. 1972, c.70—no-fault law), any other private or governmental health benefit systems, or through any similar third party liability:

7. Services or items furnished prior to January 1, 1970, or prior to the period for which the patient presents evidence of eligibility for coverage.

Medical Assistance Units

County	Address	Telephone
Atlantic	1601 Atlantic Avenue, Atlantic City 08404	(609) 344-2861
Bergen	90 Main Street, Hackensack 07601	(201) 488-5667
Burlington	Chesley and Alloway Bldg., Route 38 and Fayrestown Road, Mount Holly 08060	(609) 261-0448
Camden	530 Cooper Street, Camden 08101	(609) 365-3926
Cape May	1601 Atlantic Avenue, Atlantic City 08404	(609) 344-2861
Cumberland	7 East Broad Street, Bridgeton 08302	(609) 451-6550
Essex	796 Broad Street, Newark 07101	(101) 648-3700
Gloucester	42 Delaware Avenue, Woodbury 08096	(609) 845-7185
Hudson	100 Newkirk Street, Jersey City 07306	(201) 792-6390
Hunterdon	6 Court Street, Flemington 08822	(201) 782-1130
Mercer	324 East State Street, Trenton 08625	(609) 292-7315
Middlesex	75 Paterson Street, New Brunswick 08903	(201) 246-0653
Monmouth	320 Broad Street, Red Bank 07701	(201) 842-6440
Morris	4 Court Street, Morristown 07960	(201) 267-1700
Ocean	1851 Hooper Avenue, Toms River 08753	(201) 255-6226
Passaic	152 Market Street, Paterson 07509	(201) 523-2800
Salem	42 Delaware Avenue, Woodbury 08096	(609) 845-7185
Somerset	6 Court Street, Flemington 08822	(201) 782-1130
Sussex	4 Court Street, Morristown 07960	(201) 267-1700
Union	7 Bridge Street, Elizabeth 07201	(201) 355-8860
Warren	6 Court Street, Flemington 08822	(201) 782-1130

208th Annual Meeting May 11-14, 1974

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

GASTROENTEROLOGY—Badri Nath Mehrotra, M.D., 1540 Spring Valley Drive, Huntington, West Virginia 25701. King Georges (India) 1961. Board eligible. Hospital, solo, or group, Available, December 1973.

GENERAL PRACTICE—Jacob Sage, M.D., R.D. 1, Box 360-I, Hightstown 08520. Pittsburgh 1972. ONE DAY A WEEK ONLY. Available.

INTERNAL MEDICINE—L. A. Samarsinghe, M.D., c/o Englewood Hospital, Englewood (NJ) 07631. Board eligible. Hospital in northern New Jersey, Available.

William Dutchen, M.D., 1272 Grand Concourse, Bronx, New York 10456. NYU 1943. Board certified. Group, partnership, hospital. Available.

Arvino C. Mehta, M.D., Empire House, S.V. Road, Irla, Ville Parle, Bombay 56, India. University of Bombay 1957. Subspecialty, neurology. Group or partnership. Available.

Satish Chawla, M.D., 61-15 98th Street, 15-B, Rego Park, Queens, New York 11374. India Institute of Medical Sciences 1965. Board certified. Partnership or solo. Available January 1974.

George E. Berk, M.D., Ridder Apts. 4-5, 3-D, Valley Road, Manhasset, New York 11030. Cornell 1968. Board eligible. Subspecialty, cardiology. Group, solo, or partnership. Available July 1974.

Albert A. Maniscalco, M.D., 5300 Shady Bluff Street, Durham, North Carolina 27704. New York Medical 1966. Board certificd. Subspecialty, nephrology. Group partnership, full-time hospital. Available July 1974.

William Dutchen, M.D., 1272 Grand Concourse, Bronx, New York 10456. NYU 1943. Board certified. Group or partnership. Available.

Charles H. Michalko, M.D., 616 Susan Drive, Ann Arbor, Michigan 48103. SUNY (Buffalo) 1966. Board eligible. Subspecialty, gastroenterology. Group or partnership. Available July 1974.

OBSTETRICS-GYNECOLOGY—Che Yang Huang, M.D., 387 Carmen Road, Buffalo 14226. Taiwan University 1967. Board eligible. Group or partnership. Available.

NEUROLOGY—Bruce D. Snyder, M.D., 160 W. Montgomery Avenue, Ardmore, Pennsylvania 19003. Johns Hopkins 1968. Board eligible. Group, academic, or solo. Available July 1974.

OPHTHALMOLOGY—Richard A. Getnick, M.D., 400 Gypsy Lane, Apt. 520, Philadelphia, Pennsylvania 19144. Yale 1968. Group or partnership. Available July 1974.

ORTHOPEDICS—Tara K. Nigam, M.D., 308-353 Tache Avenue, Winnipeg, Manitoba, Canada. R2H 2A6. Lucknow (India) 1963. Board certified. Group or partnership. Available November 1973.

PATHOLOGY—Rosina M. Salazar, M.D., St. Vincent's Hospital, 153 West 11th Street, New York 10011. University of East Ramon (India) 1966. Board eligible. Assistant. Available.

Pacifico C. Ramon, Jr., M.D., 142-02 84th Drive, Apt. 1-C, Jamaica, New York 11435. St. Tomas (Philippines) 1958. Board certified (A-P). Hospital, group, or partnership. Available.

PEDIATRICS—K.N.P. Krishnaraj, M.D., 33 Terrace West, Plattsburgh, New York 12901. Stanley Medical College (India) 1961. Board eligible. Hospital group, partnership, or solo. Available, September 1973.

Sheela Kapoor, M.D., 29 Pennsylvania Avenue, Stratford (NJ) 08084. K.G. Medical College (India) 1962. Board certified. Group, partnership, or solo. Available.

SURGERY—Arnold H. Herman, M.D., 71 Davis Road, Westover AFB, Massachusetts 01022. University of Kansas 1966. Board eligible. Subspecialty, vascular surgery. Association or group. Available July 1974.

Medical Women Honor Dr. Klughaupt

At a recent dinner meeting, the New Jersey Medical Women's Association honored Dorothy Klughaupt, M.D., of Passaic, as "Woman of the Year" "for her work in the field of pediatrics and for her services to the community." Her M.D. degree came from the University of Georgia and her residency in pediatrics was taken at Bellevue Hospital in New York. She then opened a practice in Passaic, which she maintained until retirement in 1971. Dr. Klughaupt was the first woman president of the Passaic County Medical Society, having served a term in 1966. She had been previously named "Woman of the Year" by the New Jersey Manufacturers' Association (1966) and the Passaic Falls Women's Business and Professional Club (1967). She is a member of the Board of Governors of the Passaic General Hospital.

1973-1974

Committees and Councils

STANDING COMMITTEES

Annual Meeting

Arthur Bernstein, M.D., *Chairman* (1975) Maplewood
John J. Thompson, M.D., *Vice-Chairman* (1974) Caldwell
Nicholas A. Bertha, M.D. (1976) Wharton
Robert Brill, M.D. (1976) Passaic
James A. Rogers, M.D. (1974) Paterson
Robert E. Verdon, M.D. (1975) Cliffside Park
Louis F. Albright, M.D., *Secretary* Ex-officio Spring Lake

Scientific Exhibits

John J. Thompson, M.D., *Chairman* Caldwell
Frank DeMaria, Jr., M.D. Hawthorne
H. Irving Dunn, M.D. Bay Head
George L. Erdman, M.D. Summit
Martin Rush, M.D. Red Bank

Scientific Program (Sections)

Allergy
Frederic A. Schulaner, M.D., *Chairman* Westfield
Carl Dubovy, M.D., *Secretary* Boonton

Anesthesiology
Joseph A. Cox, M.D., *Chairman* Short Hills
Robert K. Egge, M.D., *Secretary* Maplewood

Cardiovascular Diseases
Lawrence A. Lubow, M.D., *Chairman* Morristown
Harry A. Roselle, M.D., *Secretary* Englewood

Chest Diseases
John J. Tambascia, M.D., *Chairman* Kendall Park
Secretary to be appointed

Clinical Pathology
Paul T. Wertlake, M.D., *Chairman* Short Hills
Stephen V. D. Chandler, M.D., *Secretary* Somerville

Dermatology
Alfred J. Shapiro, M.D., *Chairman* Long Branch
Paul A. Possick, M.D., *Secretary* Westwood

Emergency Medicine
Jack R. Karel, M.D., *Chairman* Hillside
Daniel J. O'Regan, M.D., *Secretary* Jersey City

Family Practice
Frank C. Snope, M.D., *Chairman* Flemington
Ralph J. Fioretti, M.D., *Secretary* Rochelle Park

Gastroenterology and Proctology
David Kaufman, M.D., *Chairman* Elizabeth
Samuel B. Labow, M.D., *Secretary* Plainfield

Medicine
Paul K. Bornstein, M.D., *Chairman* Asbury Park
Alexander P. Remenchik, M.D., *Secretary* Montclair

Neurosurgery and Neurology
Henry R. Liss, M.D., *Chairman* Chatham
Harold H. Goldberg, M.D., *Secretary* Hackensack

Obstetrics and Gynecology
William H. Ainslie, M.D., *Chairman* Metuchen
Michael R. DeVita, M.D., *Secretary* Paramus

Ophtholmology
Vincent B. Pica, M.D., *Chairman* Trenton
Carl J. Silodor, M.D., *Secretary* Wayne

Orthopedic Surgery
Martin L. Sorger, M.D., *Chairman* Montclair
Kenneth A. Morrissey, M.D., *Secretary* Teaneck

Otoloryngology
Joseph M. Lenczyk, M.D., *Chairman* Shrewsbury
David O. Zenker, M.D., *Secretary* Morristown

Pediotrics
Anthony P. DeSpirito, M.D., *Chairman* Neptune City
Arthur Maron, M.D., *Secretary* West Orange

Physical Medicine and Rehabilitation
Percy L. Miller, M.D., *Chairman* Orange
Norman H. Schachtel, M.D., *Secretary* Maplewood

Plostic and Reconstructive Surgery
Morton H. Goldstein, M.D., *Chm.* New Brunswick
Albert Davne, M.D., *Secretary* Trenton

Psychiotry
Alvin Friedland, M.D., *Chairman* East Orange
Thomas R. Houseknecht, M.D., *Secretary* Moorestown

Radiology
David N. Bramwit, M.D., *Chairman* Hackensack
Franklin D. Wald, M.D., *Secretary* Edison

Rheumatism
Sheldon Solomon, M.D., *Chairman* Marlton
Nicholas Cannarozzi, M.D., *Secretary* Montclair

Surgery
John J. White, M.D., *Chairman* Princeton
Eric J. Lazaro, M.D., *Secretary* Jersey City

Urology
Anthony Del Gaizo, M.D., *Chairman* Paterson
Secretary to be appointed

Credentials

Louis F. Albright, M.D., *Chairman (Secretary)* Ex-Officio Spring Lake
Elbert H. Pogue, M.D., *Vice-Chairman* (1974) Elizabeth
Frank J. T. Aitken, M.D. (1975) Bridgeton
Thaddeus Balinski, M.D., (1976) Perth Amboy
Charles E. Gilpatrick, M.D. (1975) Carney's Point
John W. Nicholson, III, M.D. (1976) Moorestown
Howard J. Rosenbauer, M.D. (1974) Hackensack

Finance and Budget

Nicholas E. Marchione, M.D., *Chairman* (1974) Vineland
David Eckstein, M.D., *Vice-Chairman* (1975) Trenton
G. Thomas DeFusco, M.D. (1974) Deal
Barry M. Kotler, M.D. (1976) Piscataway
Louis G. McAfoos, Jr., M.D. (1975) Cherry Hill
I. Edward Ornaf, M.D. (1976) Cherry Hill
Samuel J. Lloyd, M.D., *Treasurer,* Ex-Officio Trenton

Honorary Membership

Ralph M. L. Buchanan, M.D., *Chairman* (1976) ..... Phillipsburg
Charles H. Calvin, M.D., *Vice-Chairman* (1975) ..... Edison
Elton W. Lance, M.D. (1974) ..... Rahway

Medical Defense and Insurance

Paul J. Kreutz, M.D., *Chairman* (1975) ..... Elizabeth
Jesse Schulman, M.D., *Vice-Chairman* (1974) ..... Lakewood
Alfred A. Alessi, M.D. (1975) ..... Oradell
Irving P. Borsher, M.D. (1974) ..... Newark
Anthony P. DeSpirito, M.D. (1976) ..... Neptune City
William G. Kuhn, Jr., M.D. (1976) ..... New Brunswick
Louis F. Albright, M.D. *Secretary*, Ex-Officio ..... Spring Lake
William J. D'Elia, M.D., *Consultant* ..... Spring Lake
Ernest C. Hillman, Jr., M.D., *Consultant* ..... Glen Ridge
Benjamin F. Slobodien, M.D., *Consultant* ..... Perth Amboy

Medical Education

James A. Rogers, M.D., *Chairman* (1976) ..... Paterson
Frank C. Snope, M.D., *Vice-Chairman* (1976) ..... Flemington
Arthur Bernstein, M.D. (1974) ..... Maplewood
John A. Kinczel, M.D. (1974) ..... Trenton
Howard L. Nunes, M.D. (1975) ..... Jersey City
Edward H. Weiser, M.D. (1975) ..... Sussex
William F. Minogue, M.D., *Consultant* Mountainside
William S. Vaun, M.D., *Consultant* ..... Long Branch

Medical Student Loan Fund

William Greifinger, M.D., *Chairman* (1975) ..... Belleville
Charles H. Calvin, M.D., *Vice-Chairman* (1976) ..... Edison
Charles Cunningham, M.D. (1976) ..... Vineland
Joseph R. Jehl, M.D. (1974) ..... Clifton
William R. Muir, M.D. (1974) ..... Mount Holly

Physicians' Relief Fund

Joseph J. Kline, M.D., *Chairman* (1974) ..... Trenton
Frederick W. Durham, M.D., *Vice-Chairman* (1976) ..... Haddonfield
John J. Bedrick, M.D. (1974) ..... Bayonne
A. Guy Campo, M.D. (1976) ..... Westville
Frank Y. Watson, M.D. (1975) ..... Montclair

Publication

Daniel B. Roth, M.D., *Chairman* (1976) ..... Teaneck
Arthur Krosnick, M.D. (1974) ..... Trenton
John F. Marshall, M.D. (1975) ..... Trenton
James A. Rogers, M.D., *President-Elect*, Ex-Officio ..... Paterson
Louis F. Albright, M.D., *Secretary*, Ex-Officio ..... Spring Lake
Henry A. Davidson, M.D., *Editor*, Ex-Officio ..... East Orange

Revision of Constitution and Bylaws

Hillel M. Ben-Asher, M.D., *Chairman* (1975) ..... Morristown
Meyer L. Abrams, M.D., *Vice Chairman* (1974) ..... Willingboro
William A. Dwyer, Jr., M.D. (1976) ..... Paterson
Daniel J. O'Regan, M.D. (1976) ..... Jersey City
Lawrence B. Owen, M.D. (1974) ..... Woodstown
Louis F. Albright, M.D., *Secretary*, Ex-Officio ..... Spring Lake
Joseph M. Gannon, M.D., *Consultant* ..... Plainfield

Woman's Auxiliary

William J. Roe, M.D., *Chairman* (1975) ..... Englewood
Frederick W. Durham, M.D., *Vice-Chairman* (1974) ..... Haddonfield
Julius Baber, M.D. (1975) ..... Bayonne
James E. Brennan, M.D. (1976) ..... Cherry Hill
Paul Harrison, M.D. (1974) ..... Mount Holly
Alexander D. Kovacs, M.D. (1976) ..... Scotch Plains

ADMINISTRATIVE COUNCILS

Legislation

Henry J. Mineur, M.D., *Chairman* (1975) ..... Cranford
Meyer L. Abrams, M.D., *Vice-Chairman* (1974) ..... Willingboro
Donald P. Burt, M.D. (1975) ..... Morristown
John J. Crosby, Jr., M.D. (1976) ..... Jersey City
John D. Franzoni, M.D. (1976) ..... Trenton
Leon A. Fraser, M.D. (1976) ..... Trenton
Winton H. Johnson, M.D. (1975) ..... Hackensack
John S. Madara, M.D. (1975) ..... Salem
Daniel J. O'Regan, M.D. (1974) ..... Jersey City
Francis A. Pflum, M.D. (1974) ..... Asbury Park
Ernest S. Redfield, M.D. (1976) ..... Woodbury
John R. Tobey, M.D. (1974) ..... Newark
Nicholas E. Marchione, M.D., *Chairman, Board of Trustees*, Ex-Officio ..... Vineland
E. Powers Mincher, *Legislative Analyst* ..... Pennington

Medical Services

Louis K. Collins, M.D., *Chairman* (1974) ..... Glassboro
Robert E. Fullilove, Jr., M.D., *Vice-Chairman* (1976) ..... Newark
Donald T. Akey, M.D. (1974) ..... Metuchen
Robert H. Areson, M.D. (1975) ..... Montclair
David R. Brewer, Jr., M.D. (1975) ..... Woodbury
Frank Campo, M.D. (1976) ..... Trenton
Arthur C. Dietrick, M.D. (1975) ..... Mount Holly
David Flinker, M.D. (1975) ..... Moorestown
Joseph A. Lepree, M.D. (1974) ..... Elizabeth
James S. Todd, M.D. (1976) ..... Ridgewood
Sidney Woltz, M.D. (1976) ..... Union City
James A. Rogers, M.D., *President-Elect* Ex-Officio ..... Paterson
A. Guy Campo, M.D., *Consultant* ..... Westville
Karl T. Franzoni, M.D., *Consultant* ..... Trenton
Frank M. Galioto, M.D., *Consultant* ..... Bloomfield
Nicholas E. Marchione, M.D. *Consultant* ..... Vineland

Mental Health

Robert S. Garber, M.D., *Chairman* (1975) ..... Belle Mead
Edward A. Schauer, M.D., *Vice-Chairman* (1976) ..... Farmingdale
Miles E. Drake, M.D. (1976) ..... Vineland
Sidney M. Hodas, M.D. (1974) ..... Red Bank
Evelyn P. Ivey, M.D. (1975) ..... Farmingdale
Clarence W. Jaggard, M.D. (1975) ..... Woodbury
Arnold Kallen, M.D. (1974) ..... Millburn
Seymour F. Kuvin, M.D. (1976) ..... Livington
J. Lloyd Morrow, M.D. (1974) ..... Passaic
Eugene V. Resnick, M.D., (1974) ..... Paramus
John R. Rushton, III, M.D. (1976) ..... Camden
Martin H. Weinberg, M.D. (1975) ..... Trenton
William J. D'Elia, M.D., *Immediate Past-President*, Ex-Officio ..... Spring Lake

Public Health

Robert G. Salasin, M.D., *Chairman*
(1975) ..... North Wildwood
Kendrick P. Lance, M.D., *Vice-Chairman*
(1976) ..... Paterson
Frank Begen, M.D. (1976) ..... Teaneck
William M. Chase, M.D. (1976) ..... East Orange
Anthony P. DeSpirito, M.D. (1975) .... Neptune City
Henry L. Drezner, M.D. (1974) ..... Trenton
George I. Erdman, M.D. (1974) ..... Summit
Rudolph G. Matflerd, M.D. (1974) ... New Brunswick
Thomas F. McLaughlin, M.D. (1976) ..... Metuchen
John J. A. Pastore, M.D. (1975) ..... Vineland
Francis E. Rieman, M.D. (1975) ..... North Bergen
Frederick C. Steller, M.D. (1974) ..... Spring Lake
John J. McGuire, M.D., *First Vice-President*
Ex-Officio ..... Newark
James R. Cowan, Sr., M.D., *Consultant* ..... Trenton
Martin Goldfield, M.D., *Consultant* ..... Trenton

Public Relations

Howard D. Slobodien, M.D., *Chairman*
(1976) ..... Perth Amboy
John P. Kengeter, M.D., *Vice-Chairman*
(1974) ..... Toms River
Frank R. Begen, M.D. (1975) ..... Teaneck
Robert Holman, M.D. (1975) ..... Pompton Plains
Andrew G. Hudacek, M.D. (1975) ..... Morristown
Francis X. Keeley, M.D. (1976) ..... Haddonfield
John J. McGuire, M.D. (1976) ..... Newark
Gastone A. Milano, M.D. (1975) ..... Atlantic City
John A. Sakson, M.D. (1974) ..... Yardley, Pa.
Irwin Smith, M.D. (1974) ..... Willingboro
Ford C. Spangler, M.D. (1976) ..... Salem
Frank Y. Watson, M.D. (1974) ..... Montclair
John S. Madara, M.D., *2nd Vice-President*
Ex-Officio ..... Salem

SPECIAL COMMITTEE TO THE COUNCIL ON MEDICAL SERVICES

Occupotianol Heolth, Warkmen's Campensotian, and Rehobilitation

Delma W. Caldwell, M.D., *Chairman* ..... Westfield
Mathilda R. Vaschak, M.D.,
Vice-Chairman ..... New Brunswick
Elmer J. Elias, M.D. ..... Trenton
John W. Holdcraft, M.D. ..... Woodbury
Andrew G. Hudacek, M.D. ..... Morristown
Michael N. Jennings, M.D. ..... Matawan
Matthew M. Mishinski, M.D. ..... Camden
Daniel J.O'Regan, M.D. ..... Jersey City
William D. Van Riper, M.D. ..... Green Pond
Ralph A. Young, M.D. ..... Maplewood
Joshua N. Zimskind, M.D. ..... Trenton
Jarvis Smith, M.D., *Consultant* ..... Trenton

SPECIAL COMMITTEES TO THE COUNCIL ON MENTAL HEALTH

Alcohalism

Robert S. Albahary, M.D., *Chairman* . New Brunswick
Robert E. Adams, M.D. ..... Morrisville, Pa.
Edwin D. Rogers, M.D. ..... Princeton
George A. Rogers, M.D. ..... Camden
Robert F. Stuckey, M.D. ..... Perth Amboy
Robert E. Verdon, M.D. ..... Cliffside Park

Drug Abuse

Hans W. Freymuth, M.D., *Chairman* ..... Trenton
Mary Ann Bartusis, M.D. ..... Morrisville, Pa.
Granville L. Jones, M.D. ..... Summit
Francis E. Reiman, M.D. ..... North Bergen
Edward A. Wolfson, M.D. ..... Glen Rock

Ematianol Disorders af Childhaad and Adalescence

Eugene V. Resnick, M.D., *Chairman* ..... Paramus
Joseph C. Bogdan, M.D. ..... Neptune City
Jay W. Fidler, M.D. ..... Plainfield
Joseph J. Kline, M.D. ..... Trenton
Alan H. Kulick, M.D. ..... Vineland
Stanley D. Machlin, M.D. ..... Maywood
Alphonse J. Teresi, M.D. ..... Jersey City

Mental Retardation

Miles E. Drake, M.D., *Chairman* ..... Vineland
Thomas W. Madden, Sr., M.D. ..... Vineland
Eugene Revitch, M.D. ..... Plainfield
Robert A. Weinstein, M.D. ..... Newton
Harry Yolken, M.D. ..... Paterson

Neurological and Reloted Disarders

J. Lloyd Morrow, M.D., *Chairman* ..... Passaic
Michael Canelis, M.D. ..... Morristown
Josiah J. Pegues, M.D. ..... Mount Holly
Ira S. Ross, M.D. ..... South Orange
Walter Scheuerman, M.D. ..... Trenton

SPECIAL COMMITTEES TO THE COUNCIL ON PUBLIC HEALTH

Cancer Control

Roy T. Forsberg, M.D., *Chairman* ..... Westfield
Sherman Garrison, M.D. ..... Bridgeton
Warren H. Knauer, M.D. ..... Hillside
George P. Koeck, M.D. ..... Newark
Bernard J. Koven, M.D. ..... Engelwood
Charles S. Krueger, M.D. ..... Mount Holly

Child Health

William J. Farley, M.D., *Chairman* ..... Brielle
Marilyn L. Cannon, M.D. ..... Spring Lake
Herbert L. Cole, M.D. ..... Wayne
Robert E. Jennings, M.D. ..... South Orange
John J. LaMar, Jr., M.D. ..... Salem
Glenn P. Lambert, M.D. ..... Flemington
Bernard N. Millner, M.D. ..... Trenton
Milton Prystowsky, M.D. ..... Nutley
Sidney Tucker, M.D. ..... Perth Amboy

Canservatian af Visian, Hearing, and Speech

Alfonse A. Cinotti, M.D., *Chairman* ..... Jersey City
Bernard A. Balsis, M.D. ..... Trenton
Ralph L. Dicker, M.D. ..... Dover
Samuel Diskan, M.D. ..... Atlantic City
Joseph H. Kler, M.D. ..... New Brunswick
Oram R. Kline, M.D. ..... Camden
Rowan C. Pearce, Jr., M.D. ..... Haddonfield
Isadore M. Schnee, M.D. ..... Paterson
Ralph E. Siegel, M.D. ..... Perth Amboy
Ralph A. Skowron, M.D. ..... Cherry Hill
Aris M. Sophocles, M.D. ..... Trenton
Robert Stern, M.D. ..... Mount Holly
D. Blair Sulouff, M.D. ..... Morristown
Anthony M. Sellitto, M.D., *Consultant* ..South Orange

Environmentol Heolth

Richard H. Musgnug, M.D., *Chairman* Medford Lakes
Mary B. Hall, M.D. ..... Trenton
E. Spencer Paisley, M.D. ..... Haddon Heights
Frank A. Porfido, M.D. ..... Dover
Frank L. Rosen, M.D. ..... Maplewood
William I. Weiss, M.D. ..... Livingston
Meyer T. Weissman, M.D. ..... Elizabeth
Roslyn Barbash, M.D., *Consultant* ..... Teaneck
Morris Joselow, Ph.D., *Consultant* ..... Newark

Moternol ond Infont Welfore

Leopold E. Thron, M.D., *Chairman* ..... Paterson
Edward N. Comando, M.D. ..... Millburn
Robert A. Cosgrove, M.D. ..... Jersey City
Edward Foord, M.D. ..... Burlington
Charles D. Foster, III, M.D. ..... Pitman
John D. Franzoni, M.D. ..... Trenton
Calvin Hahn, M.D. ..... Vineland
John D. Preece, M.D. ..... Trenton
Daniel B. Roth, M.D. ..... Teaneck
Harold Schwartz, M.D. ..... Millburn
Jack E. Shangold, M.D. ..... Perth Amboy
Bernard N. Millner, M.D., *Consultant* ..... Trenton

SPECIAL COMMITTEES

Emergency Medicol Core

Jack R. Karel, M.D., *Chairman* ..... Hillside
R. Winfield Betts, M.D., *Vice-Chairman* .... Medford
Clifford B. Blasi, M.D. ..... Jersey City
Charles P. Campbell, M.D. ..... Hackensack
Dorson S. Mills, M.D. ..... Elmer
Frank R. Schell, M.D. ..... Wayne
Spencer T. Snedecor, M.D. ..... Hackensack

Medicine ond Religion

John J. Bedrick, M.D. *Chairman* ..... Bayonne
Reynold E. Burch, M.D. ..... Newark
Charles H. Calvin, M.D. ..... Edison
John S. Madara, M.D. ..... Salem
Thomas H. McGlade, M.D. ..... Camden
Watson E. Neiman, M.D. ..... Cinnaminson

Project Hope ond Vietnom

Thomas C. DeCecio, M.D., *Chairman* .. Cliffside Park
Harold L. Colburn, Jr., M.D. ..... Moorestown
J. Leonard Greif, M.D. ..... Dover

Retirement Plon for Physicions

Nicholas E. Marchione, M.D., *Chairman* .... Vineland
Albert F. Moriconi, M.D. ..... Trenton
Emanuel M. Satulsky, M.D. ..... Elizabeth

1973-1974 SPECIAL COMMITTEES SPECIAL LIAISON REPRESENTATIVES

Acodemy of Medicine of New Jersey

(1) Board of Trustees/Liaison Committee
(Liaison requested by Academy—6/19/66)
Edward G. Bourns, M.D. ..... Westfield
James A. Rogers, M.D. ..... Paterson
Howard D. Slobodien, M.D. .... Perth Amboy
(2) Post-Graduate Medical Education Study Committee
(Representative requested by Academy—11/15/64)
James A. Rogers, M.D., *Chairman, Committee on Medical Education* . Paterson
Frank C. Snope, M.D., *Vice Chairman, Committee on Medical Education* Flemington

Aging, Children, ond Youth, Womon's Auxiliory Committee on

(Liaison requested by MSNJ's Woman's Auxiliary—11/19/72)
James A. Rogers, M.D. ..... Paterson

Americon Medicol Associotion-Educotion Reseorch Foundotion

(Liaison requested by AMA—10/7/51)
William Greifinger, M.D., *Chairman, Committee on Medical Student Loan Fund* ..... Belleville

Audit Review Committee (1972-73 Audit)

(Appointed annually by Board to review previous year's audit)
Louis F. Albright, M.D., *Chairman* ..... Spring Lake
Edward G. Bourns, M.D. ..... Westfield
Matthew E. Boylan, M.D. ..... Jersey City
William J. D'Elia, M.D. ..... Spring Lake
I. Edward Ornaf, M.D. ..... Camden
Consultants:
Samuel J. Lloyd, M.D., *Treasurer* ..... Trenton
Nicholas E. Marchione, M.D., *Chairman, Committee on Finance and Budget* ..... Vineland

Bicentenniol Celebrotion, Committee on Notionol

(Established by Board of Trustees 7/19/70 to investigate the possibility of MSNJ's participation in the National Bicentennial Celebration in 1976)
Morris H. Saffron, M.D., *Chairman* ..... Passaic
David R. Brewer, Jr., M.D. ..... Woodbury
Peter J. Guthorn, M.D. ..... Neptune City
Fred B. Rogers, M.D. ..... Trenton

Blood Bonk Associotion, New Jersey

(Liaison requested by New Jersey Blood Bank Association 4/25/69)
David Eckstein, M.D. ..... Trenton

Blue Cross-Blue Shield Plons of New Jersey, Permonent Committee on

(Appointment of committee requested by MSP—4/16/60)
Nicholas E. Marchione, M.D., *Chairman, Board of Trustees* ..... Vineland
Matthew E. Boylan, M.D., *President* ..... Jersey City
Mr. Vincent A. Maressa, *Executive Director* .. Trenton
Equal representation from:
Medical-Surgical Plan of New Jersey
Hospital Service Plan of New Jersey
New Jersey Hospital Association

Boord of Institutionol Trustees, Deportment of Institutions ond Agencies

(Appointed by Governor for 8-year term)
Frank J. Hughes, M.D. (1979) ..... Gloucester

Board of Nursing, New Jersey State

(Liaison requested by Board of Nursing—11/21/65)
Henry J. Mineur, M.D. ..... Cranford

Bureau of Investigation, Department of Law and Public Safety

(Cooperating committee requested by Department of Law and Public Safety—5/15/73)
Board of Trustees (Reaffirmed by Board of Trustees 5/9/72)

Cardiac Advisory Panel to Director of Motor Vehicles

(Panel requested by Special Commission on Traffic Safety—9/17/61—appointed by Director of Motor Vehicles)
Harry A. Kaplan, M.D. ..... Trenton
James G. Kehler, M.D. ..... Woodbury
John C. Wood, M.D. ..... Trenton

Community Medicine Advisory Council

(MSNJ representation requested by Richard J. Cross, M.D., CMDNJ at Rutgers—12/20/70)
Arthur Bernstein, M.D. ..... Maplewood
Victor H. Boogdanian, M.D. ..... New Brunswick

Comprehensive Health Planning Agency

(Liaison requested by the Comprehensive Health Planning Agency—12/16/69)
Nicholas F. Marchione, M.D., *State Health Planning Council* ..... Vineland
Irving P. Borsher, M.D., *Health Care Costs Committee* ..... Newark
Arthur Bernstein, M.D., *Medicaid Committee* ..... Maplewood
James A. Rogers, M.D., *Medical Education Facilities Committee* ..... Paterson

Crippled Children Commission, State

(Appointed by Governor for 5-year term)
Frederick G. Dilger, M.D. ..... Hackensack

Disputed Claims, Advisory Committee to Review MSP and HSP

(Established at request of MSP—8/21/60—Quorum: 4 members)
1st District—
Ralph M. Buchanan, M.D., *Chairman* ..... Philipsburg
Charles I. Nadel, M.D. ..... Irvington
2nd District—
John J. Bedrick, M.D. ..... Bayonne
Robert A. Cosgrove, M.D. ..... Jersey City
3rd District—
John S. VanMater, M.D. ..... New Brunswick
John A. Kinczel, M.D. ..... Trenton
4th District—
John C. Clark, M.D. ..... Asbury Park
Frank J. Hughes, M.D. ..... Gloucester
5th District—
Isaac N. Patterson, M.D. ..... Westville
Nicholas E. Marchione, M.D. ..... Vineland

Education, State Department of

(Liaison requested by the Assistant Commissioner of Education—9/21/58)
William J. Farley, M.D., *Chairman, Special Committee on Child Health* ..... Brielle

Electrical Safety and Maintenance Program, Board of Advisors to the

(MSNJ representation requested by New Jersey Hospital Association—12/1/72)
MSNJ's representative will work with the Association of Hospital Engineers to develop a safety code for New Jersey hospitals.)
Bernard M. Schnur, M.D. ..... Trenton

Emotionally Disturbed Child, Advisory Council to Department of Education

(Liaison requested by Department of Education—10/28/68
William J. Farley, M.D. ..... Brielle

Epilepsy, Advisory Panel to State Director of Motor Vehicles

(Established at request of Director of Motor Vehicles—7/29/66)
J. Berkeley Gordon, M.D. ..... Rumson

Executive Committee

(Provided in the Bylaws, Chapter IV, Section 5 (b))
Matthew E. Boylan, M.D., *President (Chairman)* ..... Jersey City
James A. Rogers, M.D., *President-Elect* ..... Paterson
John J. McGuire, M.D., *First Vice-President* ..... Newark
John S. Madara, M.D., *Second Vice-President* ..... Salem
Nicholas E. Marchione, M.D., *Chairman of the Board of Trustees* ..... Vineland

Health Care Council

(Established by Board of Trustees 3/18/73 to improve liaison, exchange ideas, and discuss mutual problems with the various organizations involved in the delivery of health care services.)
American Association of Medical Assistants, State of New Jersey, Inc.
Licensed Practical Nurses' Association
New Jersey Association of Osteopathic Physicians and Surgeons
New Jersey Chapter, American Physical Therapy Association
New Jersey Dental Society
New Jersey Hospital Association
New Jersey Nursing Home Association
New Jersey Optometric Association
New Jersey Pharmaceutical Association
New Jersey Podiatry Society
New Jersey State Nurses' Association
New Jersey Veterinary Association

Health Careers Service, New Jersey

(Physician representation established by Board of Trustees 7/20/69)
Karl T. Franzoni, M.D. ..... Trenton

Health Careers Service, Resource Persons to New Jersey

(Liaison established at request of Health Careers Service—7/19/64)
Presidents of Component Societies

Health Insurance Conference

(Committee established at request of Health Insurance Council—3/24/57)
Louis F. Albright, M.D., *Secretary (Chairman)* ..... Spring Lake
Matthew E. Boylan, M.D., *President* ..... Jersey City
James A. Rogers, M.D., *President-Elect* ..... Paterson
John J. McGuire, M.D., *First Vice-President* ..... Newark
John S. Madara, M.D., *Second Vice-President* ..... Salem
Mr. Vincent A. Maressa, *Executive Director* ..... Trenton
Charles L. Cunniff, M.D. ..... Jersey City

Heart Disease, Cancer, and Stroke

University City Science Center, Philadelphia
(Established at invitation of University City Science Center—12/65)
Louis K. Collins, M.D. ..... Glassboro

Historian-Archivist

(Created at the suggestion of the Executive Director—1/13/57)
Morris H. Saffron, M.D. (Appointed 5/67) ...Passaic

Home Health Agencies, State Committee to Develop Standards for Licensure of

(MSNJ representation requested by the Secretary of the Licensure Committee of the New Jersey Department of Health—10/15/72)
David Eckstein, M.D. ..... Trenton

Hospital Association, New Jersey

(Liaison established at request of New Jersey Hospital Association—12/17/67
John S. Madara, M.D. ..... Salem

Hospital Advisory Council, State Department of Institutions and Agencies

(Appointed by the Commissioner of Health for an indefinite term)
Nicholas E. Marchione, M.D. ..... Vineland

House Maintenance, Staff Policies, and Personnel Relations

(Special Committee created by Board of Trustees—9/21/58)
Matthew E. Boylan, M.D., *President (Chairman)* ..... Jersey City
James A. Rogers, M.D., *President-Elect* ..... Paterson
Louis F. Albright, M.D., *Secretary* ..... Spring Lake
Samuel J. Lloyd, M.D., *Treasurer* ..... Trenton
Nicholas E. Marchione, M.D., *Chairman, Board of Trustees and Chairman of the Committee on Finance and Budget* .. Vineland
Mr. Vincent A. Maressa, *Executive Director* ..Trenton

HRET (Hospital Research and Educational Trust of New Jersey), Advisory Council to

(MSNJ representative requested by HRET. Appointment made by President 2/13/71. Council will assist HRET in processing data previously handled by State Health Facilities Planning Council.)
Mr. Vincent A. Maressa, *Executive Director* ..Trenton

Industrial Safety Board, New Jersey

(Appointed by the Governor—8/71)
Delma W. Caldwell, M.D. ..... Linden

Intra-Hospital Infections, Joint Committee on

(Established at request of Commissioner of Health —4/8/62)

(Department of Health wishes to discontinue participation. Matter will be taken under advisement of Board of Trustees and personnel appointed if needed.)

JEMPAC, Conference Committee with

(Established at request of JEMPAC—6/25/67)
Henry J. Mineur, M.D., *Chairman, Council on Legislation* ..... Cranford
Louis K. Collins, M.D., *Chairman Council on Medical Services* ..... Glassboro
John S. Madara, M.D., *Second Vice-President* ..... Salem

Judiciary and Bar, Conference Committee on Inter-Relations with the

(Established at invitation of Supreme Court—11/17/63)
A. Guy Campo, M.D. ..... Westville
Paul J. Kreutz, M.D. ..... Elizabeth
Samuel J. Lloyd, M.D. ..... Trenton
John S. Madara, M.D. ..... Salem
Nicholas E. Marchione, M.D. ..... Vineland
John J. McGuire, M.D. ..... Newark
Emanuel M. Satulsky M.D. ..... Elizabeth
James S. Todd, M.D. ..... Ridgewood
Matthew E. Boylan, M.D., *President, Ex-Officio* ..... Jersey City
Mr. Vincent A. Maressa, *Executive Director* ..Trenton
Mr. Joseph C. Lucci, *Executive Assistant* ...Trenton
Mr. E. Powers Mincher, *Legal Counsel* . Pennington
Equal representation from:
Supreme Court Committee on Relations with the Medical Profession

Legislation

(1) Federal Keymen
(Mechanism established by MSNJ—4/4/54—to serve as official intermediaries between MSNJ and the Federal legislators)
15 Congressional District Keymen
1 Senatorial Keyman
(2) State Keymen
(Mechanism established by MSNJ—7/13/52)
Keymen in 15 Legislative Districts/21 Component Societies

Medicaid, Negotiating Committee For

(Established by Board of Trustees to work with the State Medicaid Commission—12/22/68)
Matthew E. Boylan, M.D., *President* ..... Jersey City
James A. Rogers M.D., *President-Elect* ..... Paterson
Louis K. Collins, M.D., *Chairman, Council on Medical Services* ..... Glassboro

Medicaid Peer Review Committee

(Established by Board of Trustees 4/19/70 at the request of the Department of Institutions and Agencies. The function of the Committee will be to act upon inquiries and/or complaints originating either with the administrators of the Medicaid Program or with physicians serving under the program.)
1st District—
Nicholas A. Bertha, M.D. ..... Wharton
2nd District—
Ambrose P. Boyle, Jr., M.D. ..... Fort Lee
3rd District—
David Eckstein, M.D. ..... Trenton
4th District—
Emanuel Abraham, M.D. ..... Asbury Park
5th District—
David R. Brewer, Jr., M.D. ..... Woodbury

Medicoid Program, Medical Advisory Committee to the

(Appointment of four representatives requested by Department of Institutions and Agencies—6/12/69)
Donald P. Burt M.D. ..... Morristown
Arthur C. Dietrick, M.D. ..... Mount Holly
John D. Franzoni, M.D. ..... Trenton
Leo J. Kelly, Jr., M.D. ..... South Orange

Medical Assistance Advisory Council

(Established at invitation of State Medicaid Commission—Board action 4/20/69)
A. Guy Campo, M.D. ..... Westville
Anthony P. DeSpirito, M.D. ..... Asbury Park

Medical Assistants, (State of New Jersey) American Association of

(Liaison established by MSNJ—9/15/63)
Robert C. Anderson, M.D. ..... Newark

Medical Education of New Jersey, Office of Continuing

(Liaison requested by College of Medicine and Dentistry of New Jersey—4/20/72)
John F. Kustrup, M.D. ..... Trenton
Arthur Bernstein, M.D. (alternate) ..... Maplewood

Medical-Hospital-Nursing Conference (Tri-Partite)

(Liaison established by MSNJ—1/13/57)
Matthew E. Boylan, M.D., *President* ..... Jersey City
James A. Rogers, M.D., *President-Elect* ..... Paterson
William J. D'Elia, M.D., *Immediate Past-President* ..... Spring Lake
Mr. Vincent A. Maressa, *Executive Director* .. Trenton
Equal representation from:
New Jersey Hospital Association
New Jersey State Nurses' Association

Medical Liaison Committees

(High-level conference groups for discussion and consideration of items of mutual interest)
Matthew E. Boylan, M.D., *President* .... Jersey City
James A. Rogers, M.D., *President-Elect* ..... Paterson
William J. D'Elia, M.D., *Immediate Past-President* ..... Spring Lake
Mr. Vincent A. Maressa, *Executive Director* .. Trenton
(Where number of representatives from other organization is larger than number of MSNJ representatives, the latter will be increased from the Presidential Officers to equal the former.)
(1) Medical-Dental
(Liaison requested by the Dental Society — 6/10/51)
(2) Medical-Hospital
(Liaison established by MSNJ — 10/25/53)
(3) Medical-Legal
(Liaison established by MSNJ — 10/25/53)
(4) Medical-Nursing
(Liaison established by MSNJ — 4/4/54)
(5) Medical-Osteopathic
(Liaison requested by Osteopathic Association — 9/17/61)
(6) Medical-Pharmaceutical
(Liaison established by MSNJ — 7/26/53)

Medical School in South Jersey, Committee to Assist in the Implementation of Legislation to Establish a

(Established by Board — 5/17/67 — Appointments by President)
Louis K. Collins, M.D., *Chairman* ..... Glassboro
A. Guy Campo, M.D. ..... Westville
Sherman Garrison, M.D. ..... Bridgeton
Frank J. Hughes, M.D. ..... Gloucester
John F. Kustrup, M.D. ..... Trenton
Fred A. Mettler, M.D. ..... Blairstown
James A. Rogers, M.D. ..... Paterson

Medical-Surgical Plan Board of Trustees

(Provided in MSP Bylaws)
Matthew E. Boylan, M.D., *President* ..... Jersey City

Medicare Peer Review Committee

(Established by Board of Trustees 12/20/70 at request of fiscal intermediary. Committee will review and evaluate claims involving questions of over-utilization under Medicare. Composition of committee includes six groups of three members each in the fields of general practice, general surgery, orthopedic surgery, internal medicine, ophthalmology, and urology.

Membership Directory

(Special committee established by Board — 11/19/61)
Louis F. Albright, M.D., *Chairman* .... Spring Lake
Robert C. Anderson, M.D. ..... Newark
Matthew E. Boylan, M.D. ..... Jersey City
Daniel B. Roth, M.D. ..... Teaneck
Mr. Vincent A. Maressa, *Executive Director* . Trenton
Mr. Robert H. Lambert, *Bs. and Fin. Mgr.* . Trenton

Membership Inquiry and Complaint Mechanism

(Established at the 12/10/72 Special Session of the House of Delegates to deal more effectively with third party insurance carriers and government medical programs as they affect the practices of the membership.)

Membership Inquiry and Complaint Committee with Medical-Surgical Plan of New Jersey

Samuel Baum, M.D. ..... Passaic
Donald P. Burt, M.D. ..... Morristown
Arthur C. Dietrick, M.D. ..... Mount Holly
Karl T. Franzoni, M.D. ..... Trenton
James E. George, M.D. ..... Westville

Membership Inquiry and Complaint Committee with Medicare

Alfred A. Alessi, M.D. ..... Oradell
William H. Coleman, M.D. ..... Trenton
Richard H. DuPree, M.D. ..... Woodbury
Andrew G. Hudacek, M.D ..... Morristown
Joseph W. Schauer, Jr., M.D. ..... Farmingdale

Membership Inquiry and Complaint Committee with Medicaid

John J. Crosby, Jr., M.D. ..... Jersey City
Michael J. Doyle, M.D. ..... Neptune
Armando F. Goracci, M.D. ..... Woodbury
Frederick J. Knocke, M.D. ..... Readington
Robert E. McNamara, M.D. ..... Newark

Membership Inquiry and Complaint Committee with Other Health Insurance Carriers

Melvin J. Andrews, M.D. ..... Cherry Hill
David R. Brewer Jr., M.D. ..... Woodbury
Emanuel M. Satulsky, M.D. ..... Elizabeth
Howard D. Slobodien, M.D. ..... Perth Amboy
Robert A. Weinstein, M.D. ..... Newton

New Jersey College of Medicine and Dentistry, Student AMA

(Liaison requested by New Jersey Chapter—1/26/60)
Edward A. Wolfson, M.D. ..... Glen Rock

Nurse Pediatrician or Pediatric Nurse, Advisory Council on the

(Liaison established by the Board of Trustees—2/27/72—at the request of Rutgers University)
Harold L. Colburn, Jr., M.D. ..... Moorestown

Nurses' Association, Joint Practice Committee with the New Jersey State

(Established by Board of Trustees—7/16/72—to clarify roles and functions of nursing and medicine within the health care delivery context, with the objective being the improvement of health care delivery services.)
William J. D'Elia, M.D., *Chairman* ..... Spring Lake
Matthew E. Boylan, M.D. ..... Jersey City
David Eckstein, M.D. ..... Trenton
Henry J. Mineur, M.D. ..... Cranford
James A. Rogers, M.D. ..... Paterson
Mr. Vincent A. Maressa, *Exec. Director* ..... Trenton

Nursing Facilities, Advisory Committee on Skilled

(MSNJ representation requested by Assistant Commissioner for Health Facilities, New Jersey Department of Health—4/30/73. The Committee will revise standards for licensure of skilled nursing facilities.)
David Eckstein, M.D. ..... Trenton

Nutritian Council, New Jersey

(Liaison established by MSNJ—12/19/54)
Harvey P. Einhorn, M.D. ..... South Orange

Ochampus (Office for the Civilian Health and Medical Program of the Uniformed Services)

(1) Fiscal Agent
(Designated upon request of MSP—7/21/63)
Medical-Surgical Plan of New Jersey
(2) Special Committee on
(Established by MSNJ—9/9/56)
David Eckstein, M.D., *Chairman* ..... Trenton
George L. Benz, M.D. ..... Newark
I. Edward Ornaf, M.D. ..... Cherry Hill

Parents and Teachers, New Jersey Congress of

(Liaison requested by MSNJ's Committee on Child Health—12/20/64)
William J. Farley, M.D. ..... Brielle

Peer Review Committee, State (Estoblished at request af 1971 House of Delegotes)

1st District
George L. Benz, M.D., *Chairman* ..... Newark
Hillel M. Ben-Asher, M.D. (alternate) .. Morristown
2nd District
Robert E. Verdon, M.D. ..... Cliffside Park
James A. Rogers, M.D. (alternate) ..... Paterson
3rd District
Karl T. Franzoni, M.D. ..... Trenton
Frank C. Snope, M.D. (alternate) .... Flemington
4th District
William R. Muir, M.D. ..... Mount Holly
Earl B. Keller, Jr., M.D. (alternate) .. Cherry Hill
5th District
Louis K. Collins, M.D. ..... Glassboro
Sherman Garrison, M.D. (alternate) .... Bridgeton
Consultants:
Louis F. Albright, M.D. (MSNJ Secretary, Chairman of the Special Committee on Long Range Planning and Development, and Chairman of the Joint Ad Hoc Task Force with the New Jersey Hospital Association) ..... Spring Lake
Arthur Bernstein, M.D. (Member Ad Hoc Task Force with the New Jersey Hospital Association) ..... Maplewood
Albert F. Moriconi, M.D. (Chairman, Judicial Council) ..... Trenton
Nicholas E. Marchione, M.D. (Chairman, Board of Trustees, Joint Ad Hoc Task Force with the New Jersey Hospital Association, and Consultant to the Council on Medical Services) ..... Vineland
James A. Rogers, M.D. (President-Elect of The Medical Society of New Jersey, Chairman of MSNJ Committee on Medical Education) ..... Paterson
Mr. Jack Owen, President New Jersey Hospital Association (Member, Joint Ad Hoc Task Force with the New Jersey Hospital Association) ..... Paterson

Pension Plan, Special Committee on

(Established by Board—5/22/55 . . . Duties outlined in Article III of Pension Plan Agreement)
Nicholas E. Marchione, M.D., (Chairman) *Chairman of Committee on Finance and Budget* .... Vineland
Matthew E. Boylan, M.D., *Chairman, Special Committee on House Maintenance, Staff Policies, and Personnel Relations* ..... Jersey City
Samuel J. Lloyd, M.D., *Treasurer* ..... Trenton

Planning and Development, Committee on Long Range

(Established by Board of Trustees 2/21/71. The charge to this committee is to look to the future to devise policies and strategies which will improve the structure and operations of MSNJ.)
(Members to be appointed)

Public Health Council, State Department of Health

(Nominations for appointment by Governor requested—9/20/64)
Harry Mickey, M.D. (appointed 6/14/71) .. Maplewood

Quackery, Committee on

(Established at the request of the AMA—11/15/64)
James S. Todd, M.D. *Chairman* ..... Ridgewood
Richard B. Berlin, M.D. ..... Englewood
Charles B. Norton, M.D. ..... Woodstown

Radiation Protection Commission, Consultant to New Jersey

(Nomination for appointment to Commission requested — 7/18/65)
Bernard M. Schnur, M.D. ..... Trenton

Radiotion Protection Commission, New Jersey

(Two consultants in nuclear medicine requested by the Commission 11/66)
Frank R. Schell, M.D. ..... Wayne
John J. Thompson, M.D. ..... Caldwell

Regional Planning Council, Philadelphia Medical Library Committee

(Appointment of representative requested by Library Committee — 8/20/67)
Sherman Garrison, M.D. ..... Bridgeton

Rehabilitation Services, Division of Vocational

(Liaison requested by MSNJ's Committee on Rehabilitation — 5/65)
Jarvis M. Smith M.D. ..... Trenton

Resolutions, Committee on Annual Meeting

(Established, by Board of Trustees — 7/18/71 — to review all resolutions in advance of the annual meeting)
William J. D'Elia, M.D., *Chairman* ..... Spring Lake
E. Vernon Davis, M.D. ..... Mount Holly
Emanuel M. Satulsky, M.D. ..... Elizabeth

Safety Council, New Jersey State

(Provided in Council Bylaws)
Matthew E. Boylan, M.D., *President* ..... Jersey City
Delma W. Caldwell, M.D., *President's Representative* ..... Linden

Selective Service System, New Jersey Chairman of Advisory Committee to

(Nomination for appointment by National Advisory Committee requested by committee — 11/19/61)
Charles L. Cunniff, M.D. ..... Jersey City

Welfare Council, New Jersey

(Representative to plan meetings for annual conference on social welfare requested by Council — 5/13/66)
John J. Bedrick, M.D. ..... Bayonne

Widows and Orphans of Medical Men of New Jersey, Society for Relief of

(Liaison requested by Society — 5/17/59)
Joseph R. Jehl M.D. ..... Clifton

ANNOUNCEMENTS

Gastroenterology Series

A series of lectures on gastroenterology has been arranged jointly by Riverside, Saint Clare's, and Dover General Hospitals. All sessions are held from 9:30 to 11:30 a.m. at Riverside Hospital, Boonton. Subjects scheduled are as follows:

September 12	Inflammatory Bowel Disease
September 26	Esophagus
October 10	Peptic Ulcer
October 24	Pancreatitis
November 7	Malabsorption
November 28	Gastrointestinal Endoscopy
December 12	Hepatitis

To be announced later is a spring seminar of seven lectures on endocrinology and metabolic diseases (including gynecologic problems).

For detailed information, please write to the Joint Education Committee, Riverside Hospital, Boonton 07005, or telephone (201) 334-5000, extension 266.

Malpractice Symposium

On Saturday, September 22, 1973, the New Jersey Chapter of the American College of Surgeons and the New Jersey Bar Association are jointly featuring a colloquium on professional liability. The session opens at 9 a.m. with a continental breakfast and adjourns at 4 p.m. with a reception. The registration fee of $15 includes luncheon. The symposium will be held at the Ramada Inn, East Brunswick (Exit 9, NJ Turnpike). A star-studded faculty of physicians and lawyers will speak. For more details, please write to the New Jersey Chapter of the American College of Surgeons, 144 South Harrison Street, East Orange 07018.

Radiology Programs for 1973-1974

From 7:15 p.m. to 9:15 p.m., at the Orange Hospital Center, a series of diagnostic radiologic conferences will be held under the auspices of the Radiology Society of New Jersey and the Academy of Medicine. The dates—all Thursdays—are September 27, October 25, and December 6 (1973), and in 1974, January 24, February 28, March 28, April 25, and May 23. In addition, neuroradiology and angiography sessions are scheduled for the second Wednesday of each month at the Morristown Memorial Hospital. Finally, radiotherapy sessions are planned for the third Thursday of every other month. All of these programs are creditable toward the Medical Society requirement of 150 credits within three years. For more details, please communicate with Alexander T. Cacciarelli, M.D., St. James Hospital, 155 Jefferson Street, Newark 07105, or telephone (201) 589-1300, extension 264.

Graduate Lectures in Surgery

The following programs have been announced for the 1973-1974 "Distinguished Lecture Series" offered by the Department of Surgery of the New Jersey Medical School, CMDNJ:

October 1	Neurosurgical Treatment of Pain Abbot J. Crieger, M.D., Assistant Professor of Neurological Surgery University of Pittsburgh School of Medicine
December 10	Hiatus Hernia G. Robert Mason, M.D., Chairman Department of Surgery University of Maryland School of Medicine
January 28	Benign Lesions of the Breast William T. Fitts, Jr., M.D., Chairman Department of Surgery University of Pennsylvania School of Medicine
February 11	Metastatic Tumors of the Lung Paul C. Adkins, M.D., Chairman Department of Surgery George Washington University School of Medicine

Lectures are held at 4 p.m. in the amphitheater, 2nd floor, Martland Hospital, Newark. There is no charge. Guarded parking is available in parking lot M, 12th and Bergen Streets. The November lecture (orthopedics)

will be announced in a later issue. For further information, please write to Eric J. Lazaro, M.D., Professor of Surgery, Martland Hospital Unit, CMDNJ, 65 Bergen Street, Newark 07107.

Acupuncture Workshop in Nassau

Arrangements have been made at the Hyatt Emerald Beach Hotel in Nassau, Bahamas, for one week's intensive study program in acupuncture medicine. The dates are October 7-14. More than 20 physicians who have used acupuncture will discuss their experiences. Morning and afternoon sessions will run for three hours each. Included will be instructions on and demonstrations of dermal puncture. Registration for the week-long, ten-session workshop is $300. Low cost air fares are available.

Sponsor of the program is the American Society of Psychosomatic Medicine and Dentistry. Information is available from Fugazy Associates, 445 Park Avenue New York 10022.

ACP Graduate Courses

The American College of Physicians has arranged, through the cooperation of the institutions involved, the following graduate courses for 1973-1974:

Medical Aspects of Drug Addiction—October 10 to 12, College of Physicians and Surgeons of Columbia University, New York

Individualization of Drug Therapy—October 22 to 24, Temple University Health Sciences Center, Philadelphia

Physiology, Diagnosis, and Treatment of Electrolyte and Acid Base Disorders—January 7 to 11, University of Pennsylvania School of Medicine, Philadelphia

Current Concepts in Diagnosis and Management of Renal Disease—March 11 to 15, Cornell Medical Center, New York

Electrophysiological Approach to Diagnosis and Treatment of Cardiac Arrythmias—April 17 to 19, University of Pennsylvania Medical School, Philadelphia

Infectious Disease in Internal Medicine—June 5 to 7, Medical College of Pennsylvania (to be held at the Marriott Hotel in Philadelphia)

For information, write to the American College of Physicians, 4200 Pine Street, Philadelphia 19104.

Seminar on Sexual Inadequacy

An interdisciplinary approach for the management of sexual inadequacies will be the subject of a seminar on October 23 and 24 at the New York Sheraton Hotel, Park Avenue and 73rd Street. Physicians, nurses, and psychologists are welcome to attend. For more details, write to William S. Kroger, M.D., 9735 Wilshire Boulevard, Beverly Hills, California 90212

Cancer Seminar in October

Under the title, "Uterine Cancer: Why Isn't It Completely Controlled?", the New Jersey Division of the American Cancer Society joins the New Jersey Academy of Family Physicians in offering, on Wednesday, October 24th, a 9 a.m. to 3:30 p.m. seminar reviewing diagnostic and treatment technics for uterine cancer. The meeting will be held at the Rutgers Medical School in Piscataway. For fuller details, please write to Mr. Robert Hearn, American Cancer Society, 2700 Route 22, Union, New Jersey 07083, or telephone (201) 687-2100.

College of Physicians Regional Meetings

The American College of Physicians has announced the dates and locations of regional meetings to be held during 1973-1974. Those in our area are:

Eastern Pennsylvania Regional Meeting (ACP)—November 3 and 4, 1973, Temple University Conference Center at Sugar Loaf, Philadelphia. For information please write to Francis J. Sweeny, Jr., M.D., Thomas Jefferson University Hospital, 11th and Walnut Streets, Philadelphia 19107.

New Jersey Regional Meeting (ACP)—November 7, 1973, Cherry Hill Inn, Cherry Hill, New Jersey. For information please write to Harvey E. Nussbaum, M.D., 120 Millburn Avenue, Millburn 07041.

Course in Sexual Problems

An all-afternoon program on "Sexual Problems Met in Practice" is announced for Wednesday, November 7, 1973, starting at 1 p.m. at the Martland Hospital in Newark. The fee is $10. For more details, please write to Alvin Langer, M.D., Department of Gynecology, Martland Hospital Unit, 65 Bergen Street, Newark 07107, or telephone (201) 643-8800, extension 2705.

Ophthalmology Colloquium

The New Jersey Academy of Ophthalmology and Otolaryngology will hold its annual meeting at the Robert Treat Hotel in Newark on November 14. The morning scientific seminar will be on neuro-ophthalmology, and the afternoon assembly will feature a program on cataract. For further information, write to Marshall Klein, Eye Institute of New Jersey, 15 South Ninth Street, Newark, New Jersey 07107.

Practice Management Workshops

Practice management workshops will be offered by the AMA across the country this fall and in 1974. The AMA will assist state societies in conducting training sessions for physicians planning to go into private practice. Workshops will be limited to 25 participants. Registration fees are $35 for members and $60 for non-members. Direct inquiries to Department of Practice Management, 535 North Dearborn Street, Chicago.

Medical Cruise in January

A fourteen-day medical seminar cruise is announced for the fortnight beginning January 26, 1974. Sponsored by Albany Medical College, the cruise will be aboard the Holland-American's well-known "Rotterdam." Ports of call include St. Maarten, Montserrat, Barbados, Trinidad, Martinique, Puerto Rico, and the Virgin Islands. For more details, write to Frank M. Woolsey, M.D., Graduate Medicine Department, Albany Medical College, Albany, New York 12208.

Gastroenterology Seminar Abroad

Symposia Medica Foundation presents an international seminar entitled, "Gastroenterologic Problems in Clinical Practice." The program will be held in Jerusalem and Rome from March 15 to 24, 1974. Registration fee is $100. For detailed information, please write to Cynthia Soika, Projects Director, Symposia Medica Foundation, 305 East 24th Street (suite 17-F), New York 10010.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

September

10 **CMDNJ—New Jersey Medical School**
Martland Hospital, Newark
Kidney Transplantation in Man

11 **Academy of Medicine of New Jersey**
Paul Kimball Hospital, Lakewood
Differential Diagnosis of Jaundice

12 **Academy of Medicine of New Jersey**
Helene Fuld Hospital, Trenton
Electrolyte Imbalance

12 **Academy of Medicine of New Jersey**
Veterans Hospital, Lyons
Newer Concepts of Hepatitis

12 **Academy of Medicine of New Jersey**
Runnells Hospital, Berkeley Heights
Diagnosis in the Anemic Patient

12 **CMDNJ—Rutgers Medical School**
Academy of Family Practice, and
Academy of Medicine of New Jersey
University Heights, Piscataway
Cardiology Conference (every Wednesday through June 1974)

19 **Veterans Administration and CMDNJ**
Veterans Hospital, East Orange
Bronchitis, Asthma, and Emphysema

22 **Mountainside Hospital and Academy of Medicine of New Jersey**
Mountainside Hospital, Montclair
Shaping Today's Practitioner for Tomorrow's World

24 **New Jersey Thoracic Society and Academy of Medicine of New Jersey**
JFK Hospital, Stratford
Adult Respiratory Distress Syndrome

26 **American Heart Association and Academy of Medicine of New Jersey**
Cherry Hill Inn, Cherry Hill
Heart Disease: Role of Primary Physician

26 **Middlesex General Hospital, American Academy of Family Practice, and**

Academy of Medicine of New Jersey
Middlesex General Hospital, New Brunswick
Total Management of Arthritic Patient

27 **Radiology Society of New Jersey and Academy of Medicine of New Jersey**
Hospital Center at Orange
Xenon-133 in Diagnosis of Pulmonary Embolism

October

1 **CMDNJ—New Jersey Medical College**
Martland Hospital, Newark
Neurosurgical Treatment of Pain

2 **Academy of Medicine of New Jersey**
Holy Name Hospital, Teaneck
Sarcoidosis

3 **Academy of Medicine of New Jersey**
Veterans Hospital, Lyons
Lenkemia and Lymphoma

Middlesex General Hospital, American Academy of Family Practice, and Academy of Medicine of New Jersey
Middlesex General Hospital, New Brunswick
3 *Office Orthopedic Procedures*

10 *Multiple Sclerosis*

17 *Otologic Problems in General Practice*

24 *Neurologic Examination*

31 *Management of Thromboembolism*

9 **Academy of Medicine of New Jersey**
Paul Kimball Hospital, Lakewood
Acupuncture

10 **Academy of Medicine of New Jersey, New Jersey Lung Association, and Mountainside Hospital**
Mountainside Hospital, Montclair
Practical Pulmonary Problems

10 **Veterans Administration and CMDNJ**
Veterans Hospital, East Orange
Flow-Volume Loop Curves in Diagnosis of Pulmonary Disease

10 **Academy of Medicine of New Jersey**
Runnells Hospital, Berkeley Heights
Laboratory Interpretations

10 **Academy of Medicine of New Jersey**
Veterans Hospital, Lyons
Congestive Heart Failure

10 **Essex County Medical Society**
Carriage Trade, East Orange
Air Pollution

15 **Academy of Medicine of New Jersey**
Ancora Psychiatric Hospital, Hammonton
Depression

17 **Academy of Medicine of New Jersey**
Trenton Psychiatric Hospital, Trenton
Medical-Surgical Emergencies in Psychiatric Practice

18 **Academy of Medicine of New Jersey**
Helene Fuld Hospital, Trenton
Cardiac Arrhythmias

18 **Academy of Medicine of New Jersey**
Medical Center at Princeton
Fluid and Electrolyte Imbalance

19 **Academy of Medicine of New Jersey**
Mountainside Hospital, Montclair
Carcinoma of the Breast

24 **American Academy of Family Practice** and Academy of Medicine of New Jersey
St. Michael's Medical Center, Newark
Hematology Seminar

25 **Radiology Society of New Jersey and Academy of Medicine of New Jersey**
Hospital Center at Orange
Xeroradiography

November

Middelsex General Hospital, American Academy of Family Practice, and Academy of Medicine of New Jersey
Middlesex General Hospital, New Brunswick
7 *Pressure Neuritis*

14 *Unusual Infections*

21 *Medical and Surgical Emergencies in Psychiatry*

8 **Essex County Medical Society**
Carriage Trade, East Orange
PSRO

14 **Essex County Mental Health Association**
Veterans Hospital, East Orange
Loeser Lecture—Schizophrenias

14 **Academy of Medicine of New Jersey**
Rutgers Medical School, Piscataway
Transitory Ischemia, Cerebral Vascular Insufficiency and Strokes

21 **Veterans Administration and CMDNJ**
Veterans Hospital, East Orange
Big ACTH Possible Biologic Marker in Pulmonary Carcinoma

December

Middlesex General Hospital, American Academy of Family Practice, and Academy of Medicine of New Jersey
Middlesex General Hospital, New Brunswick
5 *Stroke Prevention and Management*

12 *Acute Drug Intoxications*

19 *Determinants of Emotional Health*

6 **Radiology Society of New Jersey and Academy of Medicine of New Jersey**
Hospital Center at Orange
Cystourethrography in Children

8 **Academy of Medicine of New Jersey**
Morristown Memorial Hospital, Morristown
Surgery of the Hand

10 **CMDNJ—New Jersey Medical College**
Martland Hospital, Newark
Hiatus Hernia

19 **Veterans Administration and CMDNJ**
Veterans Hospital, East Orange
Respiratory Muscles in Respiratory Failure

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OBITUARIES

Dr. Robert S. Gamon

A carcinoma of the lung took the life of Robert S. Gamon, Jr., M.D., on July 14, at the untimely age of 48. He was a diplomate in surgery and chief of pediatric surgery at the Cooper Hospital in Camden. He was also affiliated with the Jefferson Hospital in Philadelphia, the Zurbrugg Hospital at Riverside, and Our Lady of Lourdes in Camden. Dr. Gamon was a 1954 alumnus of the Jefferson Medical College and a Fellow of the American College of Surgeons. He belonged to our Camden County Component Society and had been a member of the MSNJ Council on Medical Services since 1968.

Dr. Harry Hoffman

Born in 1909, Harry Hoffman, M.D., died on May 24, 1973, at the age of 64. He was a 1935 alumnus of the Medical School of the University of Pennsylvania. Dr. Hoffman had his psychiatric residency at the State Hospital in Spring City, Pennsylvania, and in 1939 joined the staff at the VA Hospital in Lyons, New Jersey. During World War II, he was a major in the medical corps. Dr. Hoffman was board-certified in psychiatry and was a member of the Union County Medical Society. On his return from army service in 1947, he entered private practice in Scotch Plains.

Dr. James J. Kenny

An Orange (NJ) family doctor, James J. Kenny, M.D., died suddenly on May 25, 1973 at the age of 59. He had earned his M.D. degree at Georgetown and was active in organizational affairs of the American Academy of Family Practice. Dr. Kenny was on the staff of both St. Mary's Hospital and the Memorial Hospital in Orange. He was a member of our Essex County Medical Society.

Dr. Jack Levin

Born in 1912, Jack Levin, M.D., of our Monmouth County Medical Society, died on July 15, 1973. Board certified in internal medicine, he was Director of Medicine at Monmouth Medical Center, Long Branch, and Clinical Professor of Medicine at Hahnemann Medical College in Philadelphia. Dr. Levin had several tours of duty as president of the staff at Monmouth Memorial and was one of the founders of their coronary care unit and of the catheterization laboratory. He was a 1936 graduate of New York University Medical College in 1936.

Dr. Milton Lieberman

Milton Lieberman, M.D., a well-known Union County urologic surgeon, died on June 22, 1973, after a prolonged illness. He had been born in 1909 and was 64 at the time of his death. He was a 1932 graduate of the Medical School at the University of Iowa, and was a Fellow of the American College of Surgeons. Dr. Lieberman was affiliated with all three hospitals in Elizabeth and was a member of the Union County Medical Society.

Dr. J. Leonard Moore

On May 12, 1973, one of Mercer County's senior pediatricians, J. Leonard Moore, M.D., of Princeton, died at the age of 75. Dr. Moore received his M.D. at Columbia University's College of Physicians and Surgeons in 1925 and had practiced in Princeton since 1940. He was board certified in his specialty and a Fellow of the American Academy of Pediatrics.

Dr. Fritz C. Simon

At the age of 81, Fritz C. Simon, M.D., of Hampton (NJ) died on May 27, 1973. He was a general practitioner, who received his doctorate at the Medical School of Koenigsberg, Germany, in 1920. Dr. Simon belonged to the Hunterdon County Medical Society and was affiliated with the Hunterdon Medical Center in Flemington.

BOOK REVIEWS

Blood Diseases in Infancy and Childhood. Edition 3. Carl H. Smith, M.D. St. Louis, Mosby, 1972. Pp. 874. Illustrated. ($29.75)

The third edition of this pediatric classic is a beautiful memorial to its author who died shortly after the completion of the manuscript. It has been revised to introduce newer developments in pediatric hematology. The bibliography has been expanded and includes 1200 new references. There are 27 comprehensive chapters which should satisfy the gamut of needs from the medical student and house officer to the hematologist. The topics discussed include 2, 3-diphosphoglycerate and its role in determining the affinity of hemoglobin for oxygen; iron fortified milk; the association between immunologic deficiency diseases and lymphoproliferative malignancies; and the mechanism and etiology of disseminated intravascular coagulation.

The chapter on hemolytic anemias is exceptionally well done, and the management of the jaundiced infant is extremely thorough. The description of the exchange transfusion with its necessary equipment is an excellent reference for the neophyte or the occasional transfuser. The chapter on acute leukemia is also very complete and covers the subject in great depth.

Unfortunately most of the blood plates are in black and white and seem incongruous in our TV culture of "living color."

For those dealing with children, this up-to-date book is a valuable aid and should occupy a place in the professional's library.

Albert P. Rosen, M.D.

The Handy Home Medical Advisor and Concise Medical Encyclopedia. Morris Fishbein, M.D. New York, Doubleday, 1972. Pp. 410. ($5.95)

This revised edition merges two previous publications (Good Housekeeping's "Pocket Medical Encyclopedia" and Doubleday's "Handy Home Medical Advisor"). It, purportedly, brings their contained medical knowledge and advice up to date.

The first two-thirds of the volume is the "medical advice" section, and contains superficial, repetitious, and not always accurate advice in far too broad a field in such limited space. Many inaccuracies are found, such as so-called "standard tests" include Ascheim-Zondek, Wasserman, and Basal Metabolism. References to normal blood pressure readings are found in several sections and do not agree with each other, nor are diastolic normals given. Caloric requirements are estimated too high. Aureomycin is advised to be given with milk; measles is noted to be "not a serious disease except for very small babies." Pneumonia is said to be caused by the pneumococcus (only?); aspirin is called the "safest pain reliever;" nosebleed treatment includes cold compresses and head held slightly back. Heart failure treatment includes patient lying down; diabetic children are said to have a normal life expectancy with proper treatment. Many out-dated remedies are listed, including picrotoxin, penicillin lozenges, enterovioform, aureomycin, scarlet fever convalescent serum, and liver extract. Proprietary names of drugs are frequent (including gantrisin, atromid-S, terramycin, and choloxin) where generic names would be preferred. Sulfonamids and tetracyclines are recommended where penicillin is the drug of choice. Some passages are unclearly written, as the advice for "early puncture of the eardrum" in preventing mastoid infection, and the reference to circulation time "23 seconds during 27 beats of the heart." Vitamin E and Rubella vaccine are not included, and digitalis is not even mentioned in the care of the failing heart.

The final third of the book contains the "medical encyclopedia." In general, it is well done. It is complete, thorough, accurate and could be most helpful as a family medical reference. However, because of the many deficiencies noted in the first section, I am afraid the book will cause more problems than will be solved.

Joseph Peyser, M.D.

Law of Hospital, Physician, and Patient. Third Edition. Emanuel Hayt, L.L.B., Lillian R. Hayt, M.A. and August H. Groeschel, M.D. Berwyn, Illinois, Physicians' Record Company, 1972. Pp. 1205 ($24.75)

In 1947, the first edition of this book appeared. This is now the much-expanded third edition. Essentially the volume is aimed at hospital administrators who will find it a valuable text to be kept close at hand rather than something to be read page by page. The book was prepared in collaboration with the American College of Hospital Administrators. It is not, in any sense, a text on forensic medicine. The material, however, is approached in depth. Thus, there is a large section on the historical development of hospitals. Also reviewed are problems of hospital organization, labor relations in hospital management, staff appointments, status of salaried physicians, interns, and residents, institutional and staff liabilitiy for injuries to patients and visitors, the problem of mentally incompetent patients, and the thorny question of "meaningful consent" to the hospital procedures.

Attention is paid to medicolegal problems arising out of the hospital pharmacy and out of access to hospital records. Throughout, specific cases are cited to illustrate the advice and conclusions of the authors. At the end of the book, there is a glossary, mostly of medical terms for non-physician administrators, but also including some legal terms. Considered as a whole, this must be seen as a block-buster of a book, a sort of one-volume encyclopedia of its subject. It will earn its shelf space in any hospital administrator's library.

Henry A. Davidson, M.D.

Suicide Prevention in the Seventies. Edited by H. L. Resnick, M.D., and B. C. Hathorne, Th.D. Washington, D.C., U.S. Government Printing Office, 1973. Pp. 109 (Softback—price not stated)

The last few years have seen a rising interest in suicide prevention. Suicide seems like an especially wasteful mode of death. This well-documented brochure recounts many of the facilities needed for training in suicidology, and reviews what is needed for an effective educational program. It describes the need for research in the subject and recites the possible directions of such research.

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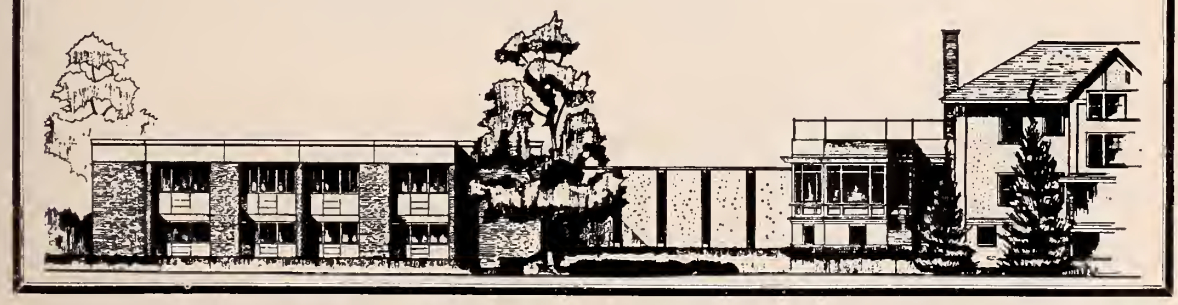
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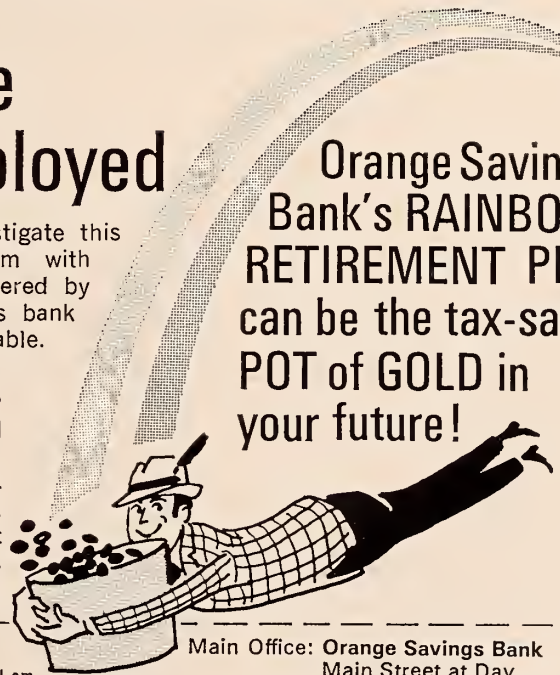
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In acute rheumatoid arthritis consider Tandearil. The anti-inflammatory action of Tandearil quickly helps reduce heat, pain, swelling, and stiffness. Results are usually seen in 3 or 4 days. Try it for a week when the symptoms defy aspirin control.

Remember that Tandearil is not a simple analgesic. It should not be used on patients responding to routine therapy. Before using, please read the prescribing information. It's summarized below.

Tandearil® helps take the heat off

oxyphenbutazone NF

Geigy

Tablets of 100 mg.

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.

(B)98-146-800-F (10/71)

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

TA 9041



More than sleep.

your choice of sleep medication is wisely based on more than sleep-inducing potential

sleep with relative safety

Chronic tolerance studies have confirmed the relative safety of Dal (flurazepam HCl); no depression of cardiac or respiratory fur was noted in patients administered recommended or higher for as long as 90 consecutive nights.

In most instances when adverse reactions were reported, they were mild, infrequent and seldo quired discontinuance of therapy. Morning "hang-over" with Dalmane has been relatively infrequent. ness, drowsiness, lightheadedness and the like have been the side effects noted most frequently, particularly in the elderly and debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

sleep for 7 to 8 hou without need to repeat dosage

No sleep cation has been as rigorously evaluated in the sleep research laboratory as Dalmane. Insomnia pa given one 30-mg capsule of Dalmane at bedtime, on average: fell asleep within 17 minutes, had fewer time awakenings, spent less time awake after sleep onset, and slept for 7 to 8 hours with no need to re dosage during the night.

eep with nsistency

Dalmane has been shown to be consistently effective even during consecutive nights of administration, with no need to increase dosage.

Dalmane (flurazepam HCl) is a distinctive sleep medication—a odiazepine specifically indicated for insomnia. It is not a barate or methaqualone, nor is it related chemically to any other able hypnotic.

When your evaluation of insomnia indicates the need for a sleep cation, consider Dalmane—a single entity nonnarcotic, nonturate agent proved effective and relatively safe for relief of nnia.

DALMANE®
(flurazepam HCl)

When restful sleep is indicated

One 30-mg capsule *h.s.*—usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*—initial dosage for elderly or debilitated patients.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE

ROCHE LABORATORIES
Div., Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Opinion & Dialogue

"Prescription drugs – who should determine the maker?"

Dispenser of Medicine

Clifton J. Latiolais
President
American Pharmaceutical Association



"Too many doctors are indi
ent to the economic consequenc
their decisions." So stated a rece
issue of *Medical News Report* (D
cember 4, 1972), an independer
weekly newsletter published by fo
AMA Chief Executive F. J. L. Blas
game, M.D.

Doctor, are you indifferent...?

In discussing an anticipatec
crease in Blue Shield rates, Dr. B
ingame's newsletter had this to s

"In general, it can be said, M
have given the impression they a
not particularly concerned with t
increase in cost of health care to
patients...

"True, an MD's training is p
marily scientific, but in the real w
of practice, all of his scientific de
sions have a price tag, or an econ
impact. The economics of health
beckon the practitioner's attentic
Concern for economics of medici

Maker of Medicine

C. Joseph Stetler
President
Pharmaceutical Manufacturers Association



When the pharmacist recon
mends that a drug product other
the one ordered be dispensed, th
prescriber invariably permits the
change when he feels the best int
ests of the patient will be served.

Shortcomings of Pro-Substitution Argument

The fact remains that it is ne
sary for the prescriber to know th
the change is being contemplatec
and to be in a position to consent
demur. Without that opportunity,
unilateral decision of the pharma
made in the absence of clinical kr
edge of the patient, could expose
to needless risks, and in addition,
jeopardize the relationship betwe
the professions of Pharmacy and
Medicine. In my view, there is not
in the pro-substitution argument t
offsets these risks.

The Issue of Drug Knowledge

Substitution advocates clain
that the primary justification for
changing the rules is the desire to
better utilize pharmacists' knowle
about drugs. Yet the pharmacist's
task to keep current on the entire
field of drug therapy, to some deg
puts him at a disadvantage. Most
often, a practicing physician will r
expert knowledge of no more than

Advertisement

uld be an obligation of medical
ctice...

"Medical societies ought to con-
t continuing campaigns to point
the substantial savings that could
ealized thru deductible insurance
l protection for catastrophic ill-
s. At the very least, they should, in
patients' interest, question the
ics of any insurance organization
t raises health care costs by forc-
policyholders to buy insurance
y may not need or want and prob-
y won't ever use.

"Too many doctors are indiffer-
to the economic consequences of
ir decisions. Too many, for ex-
ple, habitually hospitalize patients
the convenience of the MD. It's
nsense to deny such habits exist...

"Doctors, thru their medical so-
ies, have unhesitatingly appealed
heir patients for support in the
t against government interference
the private practice of medicine.
d the public in the past has re-
nded. It's time the American Med-
l Association and state and local
dical societies paid off the debt by
cisive action to hold down the cost
medical care."

st of Drugs

Insurance rates and hospital
arges are only two factors in health care costs. The cost of drugs—both prescription and nonprescription—is another.

And when it comes to drug costs, the nation's pharmacists *are concerned*. Through their national professional society, the American Pharmaceutical Association, pharmacists are advising the public to use nonprescription medication cautiously and conservatively, and to seek the advice of their pharmacist before selecting or purchasing such drugs.

Outdated Laws

The pharmacist also is aware that when it comes to prescription drugs, often he has an even greater opportunity to reduce the cost to the patient—with no sacrifice in the quality of the medication dispensed. But in many states, outdated and antiquated laws prevent the pharmacist from engaging in drug product selection. "Drug product selection" simply means that the pharmacist functions in the patient's interest by consciously choosing, from the multiple brands available, a low-cost quality brand of the specific drug to be dispensed in response to the physician's prescription order.

Much *misinformation* has been purposely spread by those who stand to gain financially by maintaining high drug costs to the public. An endless stream of propaganda has emanated from the drug industry in an effort to persuade the medical profession that these so-called anti-substitution laws should be retained. And as long as these laws are retained, the drug industry will continue its current marketing practices which contribute unnecessarily to high drug costs to patients. These practices also are inviting government agencies to expand their restrictive controls on physicians and pharmacists.

APhA Efforts

As pharmacists, we are concerned about health care costs. We hope that every physician shares our concern on this vital issue, and will give his personal support to the constructive efforts APhA has undertaken in the interest of all patients.

(For a complete discussion of drug product selection, you are invited to request a free copy of the "White Paper on the Pharmacist's Role in Product Selection" from: American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.)

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30 drugs that he selects to treat the
jority of conditions encountered in
practice. Moreover, the physi-
n's choice of a specific brand is
sed on his knowledge of the pa-
nt's medical history and current
ndition, and his experiences with
e particular manufacturer's
oduct.

Some substitution proponents
ve argued that the dispensing of a
escription is a simple two-party
nsaction between the pharmacist
d the patient, and that a substitut-
g pharmacist may avoid even a
chnical breach of contract by simply
tifying the patient that he is making
e substitution. I would judge that
w courts would be sympathetic
ward a pharmacist who substituted
thout physician approval and who
dertook a legal defense that seeks
make the patient responsible for
e pharmacist's actions.

duced Prescription Prices?

Substitution advocates are
ggesting to the consumer, and par-
ularly the consumer activist, that
duced prescription prices could
low legalization of substitution.
e have seen absolutely no evidence
justify this claim. To the contrary,
perience in Alberta, Canada, where
bstitution is authorized, suggests the opposite.

Many pharmacists understandably are concerned about the cost of maintaining multiple stocks of similar products. While there is no doubt that inventory costs rise when additional brands are stocked, it would be interesting to know how much they rise, and how many pharmacists actually stock *all* brands—of, say, ampicillin or tetracycline—or how long they keep "slow moving" products on their shelves before they are returned for credit. To ask that the industry eliminate multiple sources is to ask competitors to stop competing.

Drug Substitution—A License for the Unethical

Anti-substitution repeal would favor "corner cutting" pharmacists and manufacturers. For them, free substitution would be not a right, but a license. As an aftermath, it is quite likely that the confidence of both physicians and patients in the profession of Pharmacy would be eroded, as revelations about the unconscionable behavior of an undisciplined few were magnified in the press or in professional circles.

Summary

In short, what the American Pharmaceutical Association advocates as a broad-spectrum panacea looks to us to be not only a minority view (advocacy of substitution is by no means a uniform policy in Pharmacy), but also an extraordinarily costly and ineffective remedy, whose side effects are odious. We believe (1) that an impressive majority of pharmacists prefer to work with Medicine and with industry, for the consumer, and for the general good, (2) that they seek the privilege to substitute when the patient might gain and when the patient's doctor agrees, and (3) that they seek to work for the resolution of genuine grievances openly and professionally.

(For amplification of PMA views, please write for our booklet, "The Medications Physicians Prescribe: Who Shall Determine the Source?" It is available from: Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.)

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

ROCHE announces new BACTRIM™

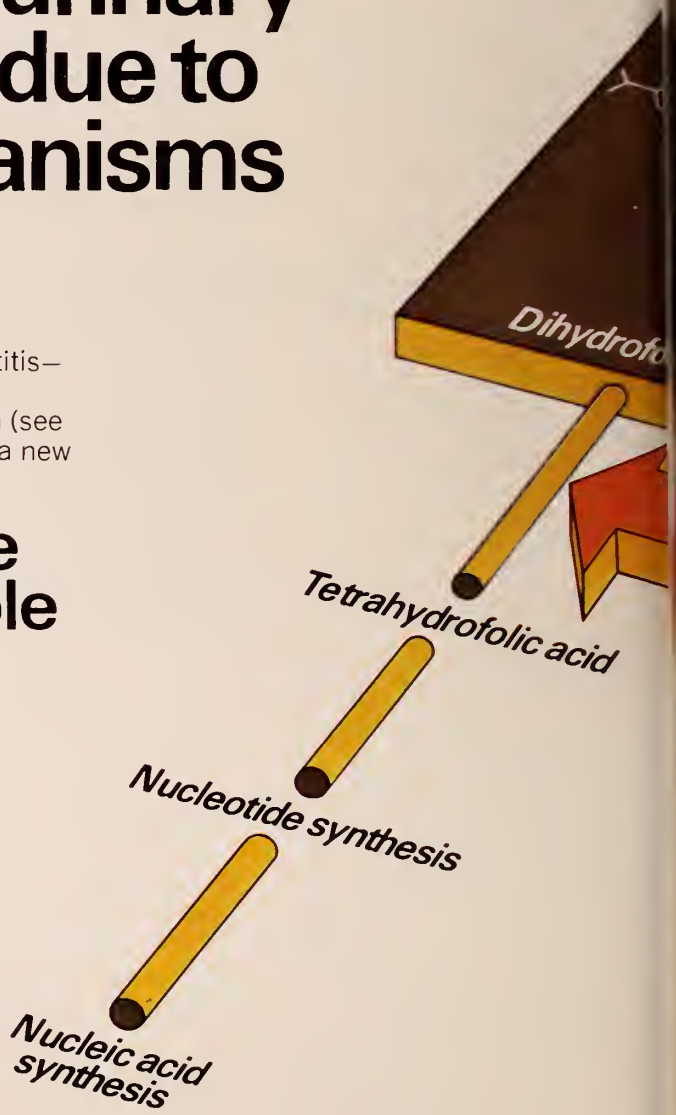
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

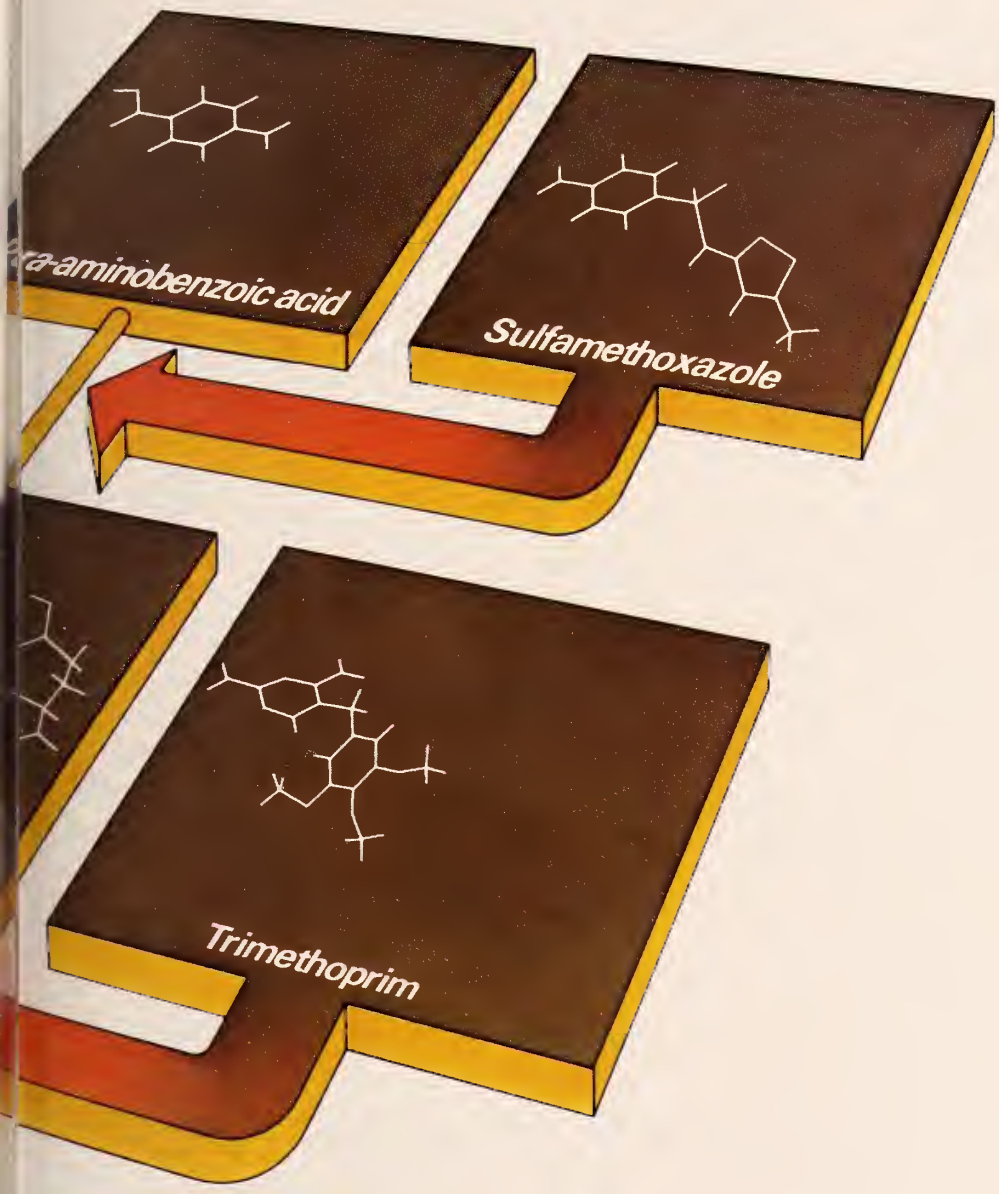
a new type of antibacterial for a two-pronged attack against chronic urinary tract infections due to susceptible organisms

Bactrim is highly effective in the treatment of these infections—primarily pyelonephritis, pyelitis and cystitis—when due to susceptible organisms. This efficacy is related to the unique mode of action against bacteria (see illustration), an action that, in effect, makes Bactrim a new type of antibacterial.

Bactrim interrupts the life cycle of susceptible bacteria

Unique mode of action interrupts the life cycle at two important points, thereby impeding the production of nucleic acids and proteins essential to these bacteria. These consecutive interruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing substrates. By competitive replacement of these substrates, they inhibit further synthesis.





ROCHE

new **BACTRIM**™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

Before prescribing, please see complete product information on last page of advertisement.

Excellent clinical response in chronic urinary tract infections even with obstructive complications

A multiclinic, double-blind study* of response to a ten-day course of therapy in 471† patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim, compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. More than half of these patients had obstructive complications.

Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after a ten-day course of therapy with Bactrim, 68.4% of patients with chronic urinary tract infections *maintained* response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. These results are particularly noteworthy considering the number of patients with obstructive complications – cases regarded as being notoriously difficult to treat.

Prescribing considerations

Clinical Limitations: Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections. Not recommended for children under twelve.

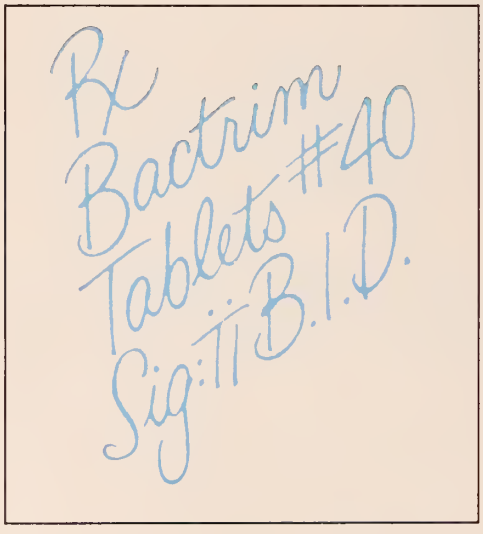
Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period.

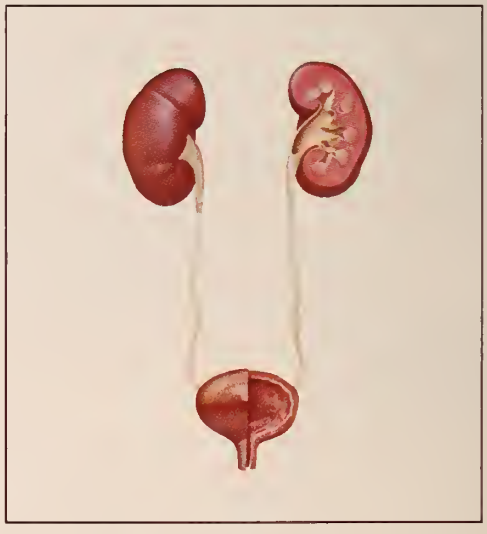
Warnings and Precautions: Both sulfamethoxazole and trimethoprim have been reported to interfere with hematopoiesis. Complete blood counts should be done frequently. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued. Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. Maintain adequate fluid intake. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Effects: Among the most common side effects are nausea, vomiting, rash, leukopenia and elevations in SGOT and creatinine.

Usual adult dosage: two tablets every twelve hours for 10 to 14 days; no loading dose required.

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110
†4 patients not available for evaluation at day 10.





new **BACTRIM**™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, N J 07110

Complete Product Information:

Description: Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light-yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is N^1-(5-methyl-3-isoxazolyl) sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

Actions: *Microbiology:* Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with *para*-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

In vitro studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

In vitro serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms
(MIC—mcg/ml)

Bacteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20) TMP	SMX
Escherichia coli	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
Proteus spp. indole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
Proteus mirabilis	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
Klebsiella-Enterobacter	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

Human Pharmacology: Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than are the concentrations in the blood. When administered together as in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frequently, indole-positive proteus species).

***Important note:* Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.**

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

Warnings: Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombopenia with purpura has been reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

Precautions: Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Reactions: For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

Miscellaneous reactions: Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration: Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

How Supplied: Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

Reproduction Studies: In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

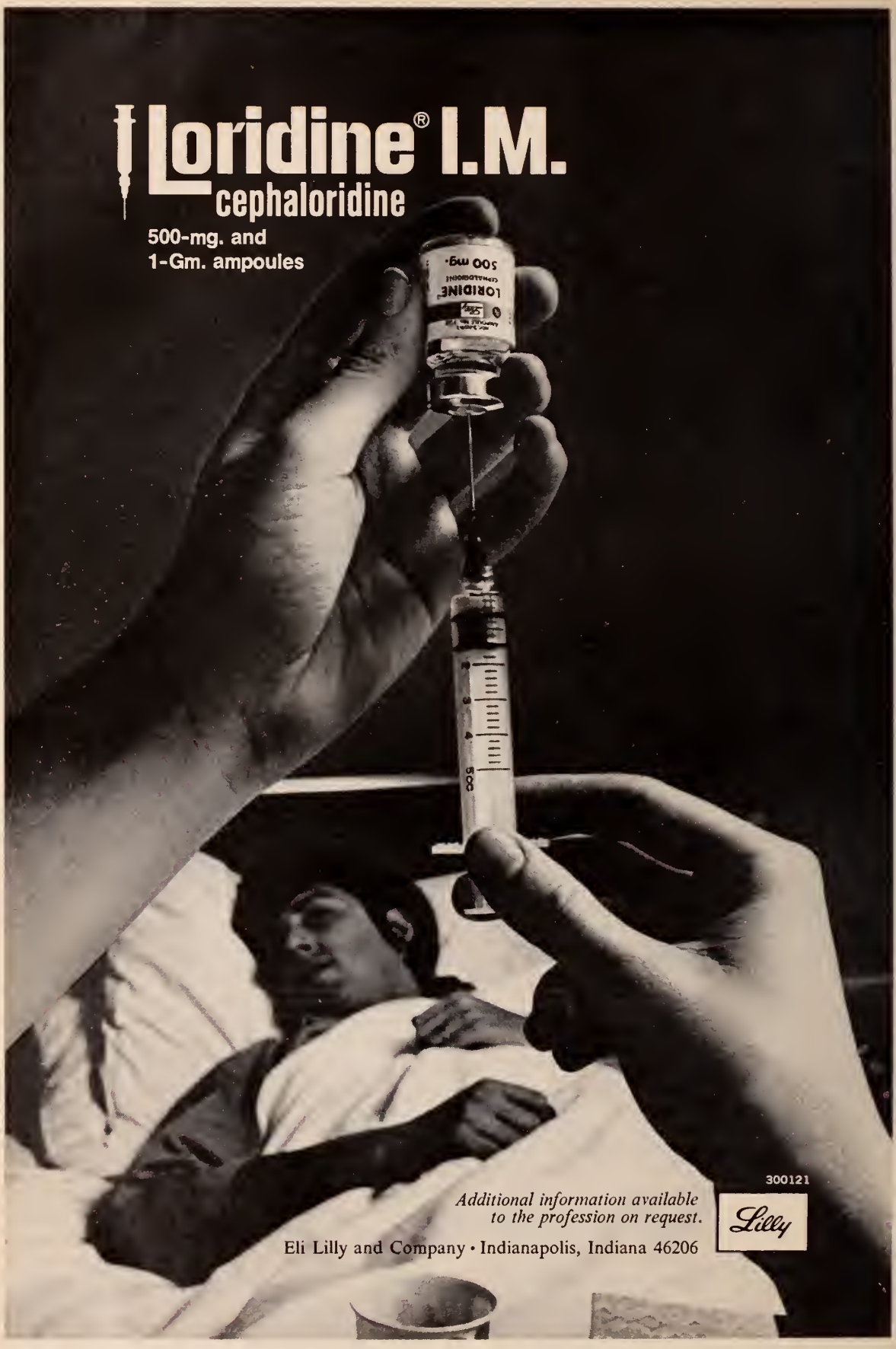
In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

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EDITORIALS

Henry A. Davidson, M.D.
1905-1973



The sudden and lamented death of Henry A. Davidson, M.D.,* on August 23rd, deprived The Medical Society of New Jersey of one of its most engaging and distinguished members. Since his assumption of the post of Editor of *The Journal,* MSNJ, in May of 1941, Doctor Davidson has been recognized nationally as one of the most gifted and discerning of the country's medical journalists. His style was penetrating, witty, and trenchant. Like Francis Bacon, he seemed to have taken all knowledge as his province, as his innumerable editorials and professional dicta indicate. History, law, medicine, economics, etymology, sociology, human relations, professional ideals and standards, and compassionate concern for his fellowmen—all had their place in Henry's heart and mind, and all are reflected in his varied and authoritative writings.

The universality of his interests and the widely ranging scope of his scholarly knowledge are seen in the titles of the six books that he produced: (1) *A Short History of Chess;* (2) *A Handbook of Parliamentary Procedure;* (3) *The World of Doctor Whatsisname* (a collection of whimsical columns on hospital psychiatry); (4) *Opportunities in Psychiatry;* (5) *Forensic Psychiatry;* and (6) *A Guide to Medical Writing.*

It was not only as an author and editor that Doctor Davidson was noteworthy. A diplomate of the American Board of Psychiatry, he was recognized as eminent in the practice of both psychiatry and neurology, and was clinical professor of psychiatry at the New Jersey College of Medicine and Dentistry from 1957 until 1969. He served with great success as Medical Director and Superintendent of the Essex County Hospital Center, an institution of more than 3,300 beds, located in Cedar Grove.

Scholar, teacher, administrator, litterateur, and medical authority, Henry Davidson was withal a modest, kindly, and congenial person. Despite the tremendous burdens of work and responsibility which he carried, he was never too busy for friendly discussions. He was truly a gifted and gracious person, whose presence in our midst made life richer for us all.

Milton once said that a good book is the life blood of a master spirit. Through his writings Henry Davidson lives on, and through the pages of *The Journal* of the past three-score years we can visit with him and share his inspiring and vital wit and wisdom as long as friendship remembers and love endures. As he once wrote in an obituary editorial concerning a fellow member of the Medical Society, whom he deeply admired, ". . . for such a man the gates of Heaven are always open."

*See obituary, page 796, this issue.

The Case of the Unfrocked Doctors

Obviously no one is in favor of incompetent practitioners. It is, therefore, difficult to oppose current enchantment with compulsory continued education. The standard requirement is that the physician take 150 hours of postgraduate instruction every three years. While many of us find the compulsory aspects of this offensive, it is hard to oppose such a program, lest it put the critic in the position of one who is in favor of sin. The various state plans are generally not as rigid as the blueprints suggest. Some give credit for attending rounds, for studying medical journals at home (though how this can be monitored is a problem), for research and teaching efforts, and even for publishing scientific papers —a ruling that may give medical editors a lot of headaches. Not yet worked out are allowances for doctors who are ill, who live in isolated communities beyond the reach of the graduate programs, or who are so expert in their specialized fields that one must ask, who will examine the examiner?

Formal lectures are certainly not the answer. To accredit such attendance would require the doctor to sign a register but some kind of supervision would seem to be needed to identify the one who makes a U-turn after reaching the "sign-in" desk. Then again, sleeping through lectures at the end of a busy day is not unknown and the certificate of attendance doesn't really affirm the sleeper's competence or knowledge of what's new. A physician in an "under-doctored" town will either have to neglect his patients as he goes out of town to take a "course" or somehow find a locum tenens.

Since most doctors today have specialty practices, the evaluation of the specialist produces another difficulty. As one gets older in his practice, his interests and studies tend to get narrower. No one can maintain highly polished skills in, or knowledge about, everything. Would the 60-year-old surgeon who has done nothing but orthopedics, ophthalmology, or otology be tested in his knowledge of liver function tests or the pharmacology of furosemide? Or would he be lectured to and tested by a fellow specialist?

The real items that made a physician a good practitioner include caring *about,* as well as caring *for* patients, conscientiousness, readiness to respond, and other factors that are not checked by a computer or taught by seminars or lectures.

One must think also about the sanctions for *not* participating or flunking the tests. Loss of Society membership? Loss of hospital affiliation? Loss of license to practice? How much evidence will be needed before a physician is unfrocked?

Opium Revisited

Some years ago, it was suggested that the way to curb heroin addiction would be to cut off opium at its source. The largest single country to grow and export products of the poppy was Turkey. So, largely on the basis of pressure from our own country, Turkey stopped the cultivation of *Pappaver somniferum,* and it is now estimated that the worldwide deficit for legally supplied opium will this year approximate 300 tons! This will not only squeeze out morphine, but also codeine, paragoric, nalorphine, dihydrocodeine, oxycodone, and papaverine. It is true that several synthetic painkilling drugs have been developed, but they have severe and rather narrow dosage limits or side effects. In our hostility to heroin, we may forget that opium, especially morphine, has valuable pharmacologic effects. Most practitioners will probably say that for the pain of a myocardial infarction or a terminal carcinoma, no synthetic is quite as effective as morphine. No one wants to encourage wider cultivation of the poppy, but the medical community should be heard as to whether by this kind of boycott of opium (a screen which is still pretty porous) we do not unjustifiably interfere with our chance of practicing good medicine.

ORIGINAL ARTICLES

Wheezing in the infant is usually satisfactory to treat —if you know how. And here's how!

Wheezing in the Child Under Two Years

Arthur F. Fost, M.D./Belleville*

Every physician who deals with children has been confronted with a dyspneic, cyanotic, apprehensive, wheezing infant, and, of course, the panic-stricken parents. All concerned, including the doctor, are wondering if the next breath is to be the last one. Not as dramatic, but far more frequent, is the almost everyday office occurrence of the young child with wheezing associated with or following a "cold."

I define wheezing as an expiratory musical sound (that may change after change of position, coughing, or epinephrine), caused, for the most part, by spasm and mucus in the bronchioles. It can occur in allergic or nonallergic children, but the differential is crucial for long-term management. It is very common in the child under two years because of his narrower bronchioles as compared to the older child or adult. The bronchioles can be obstructed by mucus or edema. This can be secondary to allergy and/or infection. Normally, the bronchiole expands during inspiration, and its diameter narrows during expiration. With obstruction of the bronchioles from mucus and edema, the peripheral alveoli become expanded with air, and as the lungs try to push this air out of the obstructed areas, wheezing results. This pathophysiology gives us the typical clinical picture of the child with the expanded chest diameter, using all his accessory muscles of respiration to push the air out. X-ray of the chest in severe cases will confirm this hyperaeration. The younger child is peculiarly susceptible to respiratory problems in general. His bronchial musculature is poorly developed and he is incapable of producing an effective, mucus-clearing cough. Total lung volume is more than proportionately decreased because of the relatively larger mediastinum (thymus and heart), and the relatively larger liver and stomach that impair diaphragmatic respiration.

Differential Diagnosis

When a wheezing child is first seen, a brief differential diagnosis must be considered to avoid inappropriate management. A wheezy type of respiration will be heard in infants with laryngeal stridor, flaccid epiglottis, and tracheomalacia. These infants manifest primarily inspiratory difficulties from their upper airway obstruction. Symptoms are usually present from birth, but become lessened with age. Extension of the mandible usually results in obvious improvement. A foreign body in the trachea or lower airways can produce reflex bronchospasm and must be ruled out in all children.

Among causes of wheezing are tuberculosis, pertussis, staphylococcal pneumonia, cystic fibrosis, and bronchiectasis. All of these must be considered in the child wheezing for the first time. Less commonly, wheezing can be secondary to antibody deficiency syndromes, pulmonary hemosiderosis, hypersensitivity lung diseases, and parasitic infestations. The latter illnesses usually have other clinical clues, and need not be considered in every wheezing child. The most common causes of

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wheezing in the child under two years of age are bronchiolitis and bronchial asthma.

Bronchiolitis and Bronchial Asthma

Bronchiolitis is an acute respiratory disorder of infants and young children, often occurring in epidemics. It is characterized by a preceding upper respiratory tract infection, followed by cough, shallow rapid respirations, and expiratory wheeze. It is usually due to the Respiratory Syncytial Virus (RS Virus), but can also be caused by a variety of viral agents. The principal lesion is an inflammatory obstruction of small airways. The virus on occasion can cause destruction and necrosis of alveolar and bronchiolar tissue. Necrotic debris, fibrin, and edema occlude the airways.

Bronchial asthma can also be heard as wheezing following what appears to be an upper respiratory tract infection. This wheeze is due to bronchospasm of different etiology. Bronchospasm in the allergic child results from release of chemical mediators (especially slow reacting substance of anaphylaxis or SRS-A) secondary to antigen-antibody interaction acting on mast cells and neutrophiles.

Bronchiolitis as a rule does not recur, whereas bronchial asthma is a chronic disorder. It is not unusual for the older asthmatic child to have a history of "recurrent bronchiolitis" in infancy, but these episodes were more likely misdiagnosed asthmatic attacks. It has been said that wheezing in infants under two is secondary to bronchiolitis, and over the age of two is bronchial asthma. This concept may have some statistical validity, but cannot be used for the individual child. Also, the statement is frequently made that if wheezing clears on epinephrine administration, it is allergic in origin, and if non-responsive to epinephrine, it is infectious or bronchiolitis. This is also misleading, because the edema in bronchiolitis will respond to sympathomimetic medication to some extent, and the true asthmatic will not always respond to epinephrine, especially if he is severely acidotic, or has airways occluded by mucus, or has an associated infection.

It is important to differentiate bronchiolitis from bronchial asthma especially for long-term follow-up, as asthma is recurrent unless correct measures are instituted. Zweiman, *et al.*[1] followed a group of patients over a five year period. They had a diagnosis of bronchiolitis in infancy. Out of a total of 35 children, 15 had recurrent wheezing after the age of two. When they compared the recurrent wheezing children with the others, they found a highly significant correlation between the persistence of wheezing and the presence of a positive family history of allergy. In a more recent study, Polmar, *et al.*[2] studied two groups of infants with epidemic and sporadic bronchiolitis, and this was correlated with family history, viral studies, and IgE levels. They were able to correlate elevated IgE with the sporadic but not the epidemic group and suggested they may indeed have been experiencing their first attack of asthma. I have found in my own experience, that in an infant who is wheezing for the first time, bronchial asthma is the most likely diagnosis. If the family history is negative for allergy, bronchiolitis is more probable.

Laboratory Studies

The minimum laboratory studies for any child with an initial episode of wheezing should include a complete blood count and a chest x-ray. Eosinophilia is commonly seen in the allergic child, but if over 20 per cent should arouse suspicion of parasitic infection. Lymphopenia is seen in some forms of antibody deficiency syndrome, and lymphocytosis can be indicative of the pertussis syndrome. Anemia can be secondary to chronic infection, and, if present, can retard effectiveness of standard measures used to treat wheezing.

To be considered in individual cases are cultures, especially nose, throat, and blood. Antibody deficiency states can be suspected by chest x-ray (absence of thymus) and blood count as noted before (lymphopenia). They can be confirmed by a battery of tests including serum immunoglobulins, isohemagglutinins, Schick test, phytohemagglutinin stimulation of lymphocytes, and bone marrow for

plasma cells. A sweat test should be considered in any child with chronic chest symptoms. A nasal smear for eosinophiles has limitations but can give a clue to the presence of allergy.

Skin testing for delayed hypersensitivity to tuberculosis, histoplasmosis, coccidiomycosis, and others, can be considered as clinically indicated. Skin testing for immediate hypersensitivity or the standard allergy skin tests can be done at any age, but should be interpreted with caution. Skin testing for foods does not yield useful information, but selected inhalant antigens can give diagnostic clues.

Special procedures to be considered on an individual basis are bronchoscopy, electrocardiogram, gastric washings for hemosiderin laden macrophages and tubercle bacilli. Pulmonary function testing can be done in infants but requires sophisticated equipment.

For the child with wheezing severe enough to require hospitalization, blood gas studies should be performed. This is one of the few laboratory studies that can supplant clinical judgment in assessment of severity of illness. The most valid and accurate results are from arterial blood taken directly from an artery, but "arterialized" capillary blood can be used if taken correctly. This latter sample is usually taken from a finger or toe, after the extremity has been prepared by either immersion in very warm water for several minutes or wrapped in hot towels for five minutes. Then, a clean, deep, jab is made with a lancet and the first drop of blood is wiped away. The blood should be flowing freely, and capillary tubes are filled carefully, without air bubbles. The determination must be made immediately. Venous blood can also be used, but is more difficult to interpret.

The normal values are: pH, 7.38 to 7.42; pCO_2, 33 to 47 mm. Hg.; pO_2, 95 to 100 mm.; oxygen saturation above 94 per cent; and base excess (BE) minus 2 to plus 2.

Treatment of Bronchospasm

For the infant in acute respiratory distress secondary to wheezing, epinephrine is the most effective bronchodilator and the initial drug of choice. The dose is 0.01 ml. per kg. of a 1 to 1000 epinephrine solution. This can be repeated in twenty minutes if the initial response is not adequate, but should not exceed three doses in twenty-four hours. If the child remains in acute distress after epinephrine, he is by definition in "status" and should be hospitalized for further therapy.

If the patient has responded well to epinephrine, or is not in severe distress when first seen, he can be sent home on an oral bronchodilator. We favor ephedrine sulfate, 0.5 mgm, per kg. per dose, given every four to six hours. We also give expectorants—usually saturated solution potassium iodide (SSKI) in dose of five drops in juice four times daily. We advise restriction of solid food, mainly to increase liquid intake, but also because nausea or vomiting is commonly present. We also recommend room vaporizers or humidifiers to moisten the upper airways, and thereby ease discomfort.

Corticosteroids are not used for the outpatient, because of their great potential for abuse and serious side effects. We rarely use antibiotics in clear-cut bronchiolitis or bronchial asthma.

If the child is in severe distress, and unresponsive to epinephrine, he is admitted to the hospital. All hospitalized children with bronchospasm are treated initially with humidified oxygen in tents. We are no longer using the ultrasonic mist machine, because of reports that airway obstruction can be increased. Oxygen is used before the potent bronchodilator drugs are given, because these severely affected children are always anoxic, and the initial effect of the bronchodilator drug can be further to depress the arterial oxygen (paO_2).

Most hospitalized patients require intravenous therapy. They are frequently dehydrated from lack of oral intake, vomiting,

and increased insensible fluid loss secondary to increased respiratory rate and mouth breathing. The young infant with bronchiolitis may be too exhausted to drink by mouth, and further dehydration causes thickening of mucus in the airways with increased distress. The intravenous also serves as a convenient route for administering other medications, without disturbing the child. For our initial fluid therapy, we treat as though moderate dehydration is present, or approximately 2400 milliliters per square meter body surface area for the first twenty-four hours. For initial fluid we use 5 per cent dextrose in half-normal saline. For bronchodilation, we use amino-phylline, 3 to 4 mgm. per kg., given by slow intravenous push (over 5 minutes) and repeated every six hours as clinically indicated.

On admission, all children have arterial blood drawn for blood gases analysis. If the child is clinically acidotic, we do not wait for the results, but give a push of sodium bicarbonate, 2 mEq. per kg. If the blood gas studies show that pH is significantly low (below 7.25) we continue with bicarbonate therapy in effort to keep the pH at more normal levels. For correction of acidosis, one-half of the calculated base deficit is corrected by intravenous push, and the other half, given by intravenous drip over six hours. Repeated assessments of blood gases are made every one to six hours as indicated. The amount of bicarbonate to give can be calculated by the following formula: calculated base deficit (in mEq. sodium bicarbonate) equals body weight (kg.) times 0.3 (assumed bicarbonate space) times total base deficit (derived from Siggarg-Anderson nomogram and reported with blood gases). In simple terms, to correct acidosis, mEq. sodium bicarbonate to give equals 0.3 times body weight (kg.) times base deficit; half this amount is given by intravenous push and the remainder by intravenous drip over six hours, with corrections made subsequent to future blood gas studies.

Most of these children have low pCO_2 values because of hyperventilation, but a rise in pCO_2 is an ominous sign signaling increasing bronchospasm. If the pCO_2 rises to 65 or above, he is in respiratory failure and assisted ventilation is required.

Appropriate antibiotics are given if pneumonia is suspected or confirmed by x-ray, but are not used routinely. Corticosteroids have not been demonstrated to have any beneficial effect in bronchiolitis, but are used in status asthmaticus, especially if there is a life-threatening situation. Not all hospitalized patients require steroids. If they are used, we use hydrocortisone, 4 mgm. per kg. per dose by intravenous push, and repeat every six hours as indicated. It can be discontinued as soon as the patient is out of acute distress.

If, in spite of all these measures, the pCO_2 is rising, assisted ventilation may be indicated. This can be done via a mask over the face, but, if the child is in respiratory failure, will require endotracheal or nasotracheal intubation and a volume respirator. This should be a rare event, and when necessary requires a team approach including an anesthesiologist, inhalation therapist, and otolaryngologist.

Long Term Management

If the child is wheezing from bronchiolitis, the parents can be reassured that this is not likely to recur. If, however, the family history is strongly positive for allergy, or if the child has a history of recurrent wheezing, the parents should be told that the child has bronchial asthma and measures should be instituted to prevent future episodes and chronic illness. I see no point in using euphemisms as asthmatic bronchitis, or allergic bronchiolitis, or other meaningless terms that only delay needed management.

Initially, the parents should be advised on means of maintaining a hypo-allergenic environment at home, and given advice on dietary precautions. They should also have an oral bronchodilator on hand to use at the first sign of chest symptoms. Referral to an allergist may be necessary if the child continues to wheeze.

Skin testing in the infant can be meaning-

ful if not overdone. Those children who continue to wheeze in spite of all other measures should undergo hyposensitization therapy.

In general, these children are satisfying to treat, in that the physician can reverse serious and chronic illness, in a relatively short period of time, by simple measures.

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50 Newark Avenue

Screening in Sickle Cell Programs

Some of the blood tests used in mass screening programs for sickle cell anemia emergence among American blacks have not been sufficient to find all of the hemoglobin anomalies that can cause serious health problems and that can be genetically transmitted, says a report in the May 28 *Journal of the American Medical Association.* This comes from the Center for Disease Control of the U.S. Public Health Service at Atlanta.

"There is little question that sickle cell screening should be done," says Robert M. Schmidt, M.D., author of the report. "Without a uniform standard of screening, the program will not succeed. With well over 100 screening programs now in existence, we are too late to prevent past errors in diagnosis. There is still time, however, for screening programs to change to methods that will allow identification of the clinically important abnormal hemoglobins."

The CDC is currently offering training courses in laboratory methods of blood testing for anyone involved in the screening process. These courses, which are free, stress the cellulose acetate electrophoresis test. The test is inexpensive, easy to perform, allows differentiation of sickle cell disease from the relatively benign carrier state, and detects other common abnormalities so that effective counseling is possible.

Sickle cell anemia affects at least one in each 500 black infants. A census study in 1967 showed 1,155 new cases of the disease in that year. The sickle cell trait is present in 8 to 14 per cent of American blacks. Fortunately, the trait actually causes the disease in the offspring of only a relatively small portion of the carriers.

Several basic sickle cell screening tests can be done in the laboratory with blood samples. One most widely used in the past is the sodium metabisulfite test. It requires interpretation by an experienced technologist, is time-consuming, and is not well adapted to large-scale screening. The best of the tests, says Doctor Schmidt, is cellulose acetate electrophoresis.

"The National Sickle Cell Disease Program, the Howard University Sickle Cell Conference, and the New York City Sickle Cell Conference, all recommend electrophoresis as the primary screening test for any hemoglobinopathy program. Until a better method is developed, a uniform national program will be possible only if all those involved in sickle cell screening come to an agreement on methodology."

When findings suggest a diagnosis of thoracic outlet syndrome, the authors advise arteriography of the subclavian artery to demonstrate the exact area and etiology.

Thoracic Outlet Syndrome*

Arteriographic Diagnosis in Pediatrics

Marvin R. Agran, M.D.,
E. Arthur Kratzman, M.D., and
Michael M. Lazorek, M.D./Plainfield

The "Thoracic Outlet Syndrome" is fairly common in adults, but the diagnosis is rare in the pediatric patient. The pre-operative diagnosis of the exact location and etiology of the arterial lesion is important to the surgeon attempting correction of the causes for this syndrome. (Figures 1 and 2).

A 15-year-old female was admitted with recent onset of pain and weakness in the left upper extremity and inability to raise the left upper extremity to her head. These symptoms began a few hours after the young girl's upper extremity had been maintained in an outstretched position. There was no previous history of trauma, neck discomfort, or difficulty in lifting objects. Neurologic examination revealed a decrease and obliteration of the left radial artery pulse when abducting and raising the left upper extremity and turning the head and neck to the opposite side. Weakness of the C5-C6 nerve root innervation of the left deltoid and brachio-radialis muscles was present. Hand strength and finger grasp were normal.

Radiographically, the chest x-ray was normal with no cervical ribs or clavicular fracture. *Via* Seldinger technic, a selective left subclavian arteriogram was done with the left upper extremity in neutral and abducted

*This case report is from the Muhlenberg Hospital, Plainfield (NJ), Department of Radiology.

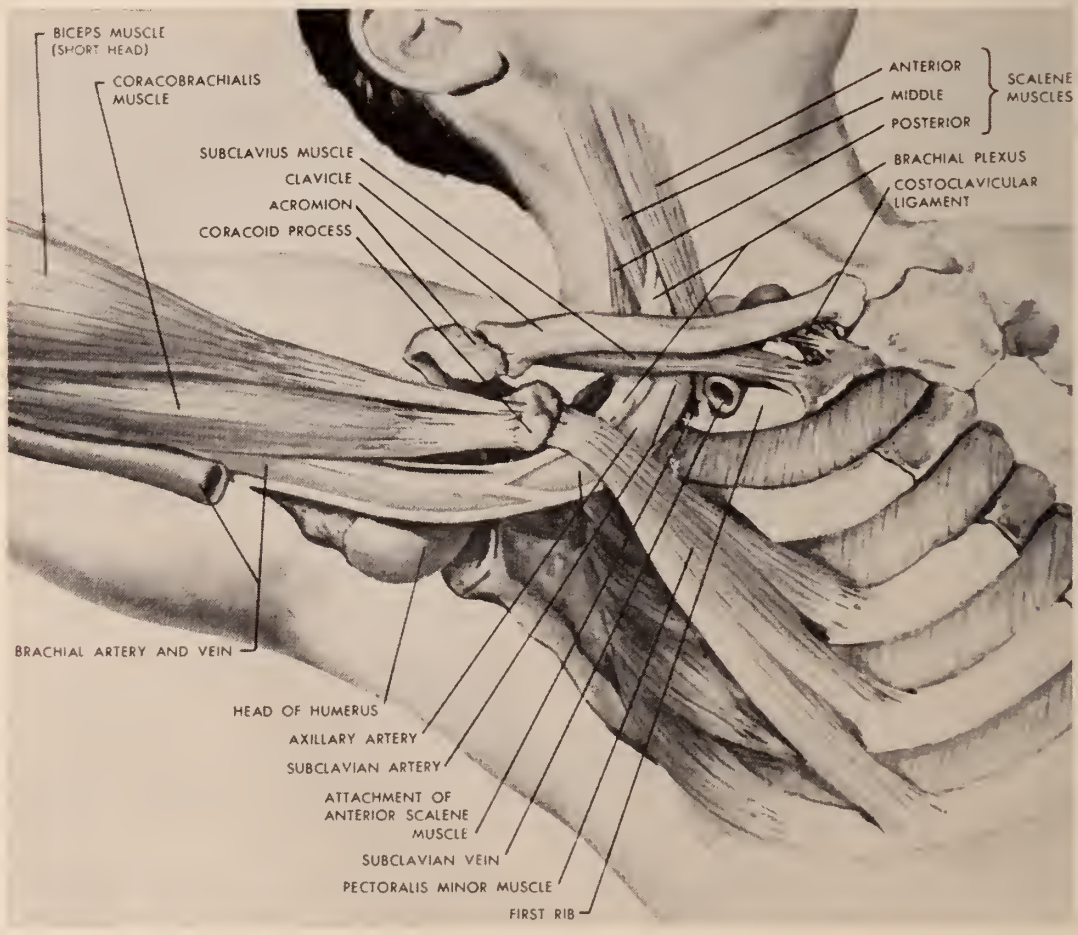


Figure 1

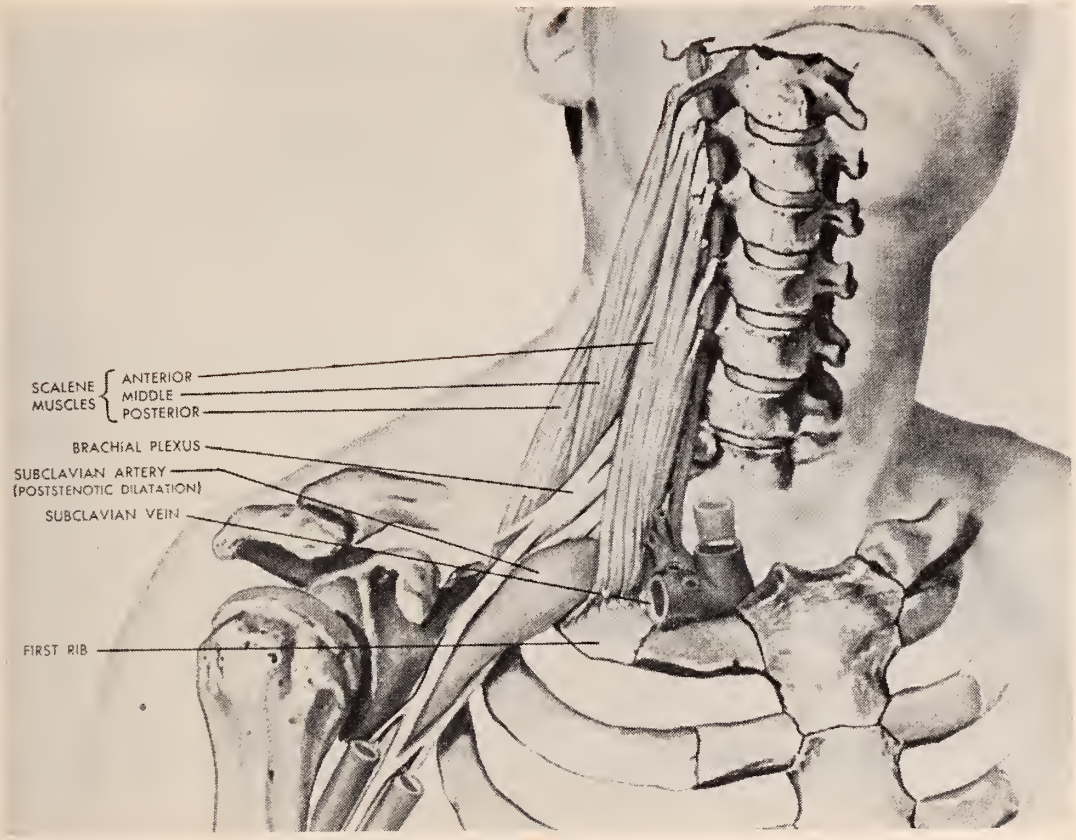


Figure 2

positions which demonstrated a narrowing of the proximal left subclavian artery where it passes through the scalenus muscle sling. (Figures 3 and 4.)

Surgery disclosed thoracic outlet syndrome by scalenus muscle compression of the subclavian artery and brachial nerve plexus. An anterior scalenotomy relieved the pressure from the adjacent artery and nerve eliminating the symptoms.

The youngest infant described having this syndrome was an 8-month-old cited by Workman, Jarvis, and Thomas.[1] They made the diagnosis clinically, not arteriographically, because the child had bilateral cervical rib development compressing the adjacent artery and nerves.

Good clinical judgment may make one suspect this syndrome, but it requires arteriographic study to pinpoint the exact area involved.[2,4] In the past, thoracic outlet syndromes were designated according to their anatomic etiology; the cervical rib syndrome, scalenus anticus syndrome, pectoralis minor syndrome, hyper-abduction syndrome, and costo-clavicular syndrome.[2 through 16]

Seldinger technic and catheter insertion of the femoral artery is the choice. This method has been adequately described[2] for its ease

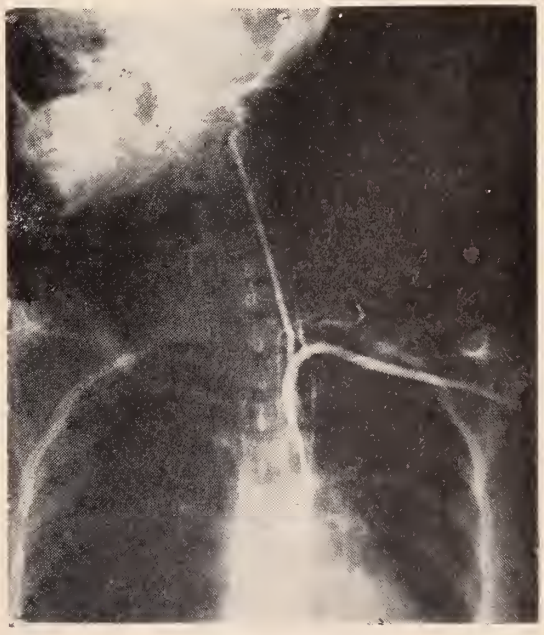


Figure 3



Figure 4

and diagnostic efficiency permitting serial filming of the subclavian artery after selective injection of iodinated contrast medium with the upper extremity in various positions.[2,3]

Differential Diagnosis

Scalenus Anticus Syndrome: This is the best-known and most publicized of the various causes. It was described in 1905 by Murphy[6] who explained the neurovascular mechanism resulting from pressure upon the artery, vein, and nerves between a cervical rib and scalenus anticus muscle.

Diminution of the radial pulse results from the narrowing of the interscalene space by the scalene muscle complex compressing the subclavian artery. This can be clinically induced by the Adson Maneuver of extending the neck, turning the chin to the side involved, abducting the involved upper extremity and taking a deep breath. This maneuver was modified in 1962, by Lang[2] who turned the chin away from the involved side and produced maximum outward rotation of the upper extremity.

Four types of scalenus anticus syndromes have been decribed and recognized;[17] (a) due to pressure by the scalenus medius tendon at the entrance into the scalenus tunnel; (b) torsion of the artery between the scalenus anticus and medius tendon; (c) compression of the artery over its entire course through the tunnel; and (d) linear cut-off of the artery at the entrance of the tunnel distal to the origin of the thyro-cervical trunk and internal mammary artery.

Cervical Rib Syndrome: This defect is readily recognized by teleoroentgenogram of the chest. It was described in 1860, by Willshire.[14] Resection of the rib and splitting of the scalenus anticus and medius muscles are necessary in correction of this condition.[6, 9, 11]

Pectoralis Minor Syndrome: Although this mimics the scalenus anticus syndrome, arteriography will differentiate the two conditions.[19] A marked depression at the junction of the subclavian and axillary arteries occurs due to compression by the pectoralis minor tendon. Lord, *et al.*,[4] and Wright[15] produced this impression by abducting the shoulder in a downward and backward manner.

Hyperabduction Syndrome: This is considered to occur by a combination pressure effect by the subclavius, pectoralis minor muscle, head of the humerus, coracoid process, and costo-coracoid ligament. This will produce a decrease in the radial pulse, paresthesia, and tingling of the fingers with acrocyanosis. Pressure upon the subclavian artery over a long segment with splaying of the artery around the head of the humerus is seen on arteriography.[18] This syndrome causes pressure upon the subclavian vein producing thrombus of the vein.

Costo-Clavicular Syndrome: This occurs following a fracture of the clavicle or first rib with a large callus developing at the fracture site and compressing the adjacent artery or vein. Post-stenotic dilatation of the subclavian artery on the arteriogram at the old fracture site suggests the diagnosis.

Summary

A case of a 15-year-old female is presented with the clinical diagnosis of thoracic outlet

syndrome. Studies utilizing selective arteriography of the subclavian artery demonstrated the exact area and etiology. This provided the surgeon with the information needed to plan his surgical approach. This procedure should be utilized (whenever the clinical findings suggest thoracic outlet syndrome) prior to any corrective surgery.

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Limited Surgery in Treating Breast Cancer

A current trend toward limited surgery for breast cancers is labeled a "great leap forward" in treating this malignancy, in an editorial in the May 21 issue of *JAMA.* The radical mastectomy still is the best hope of effecting long-term cures of breast cancer, says the editorial, written by C. D. Haagensen, M.D., of Columbia University. Two less drastic technics have received attention of late—lumpectomy, in which only the malignant lump in the breast is removed; and simple mastectomy.

"We already know enough regarding the inferiority of lumpectomy and simple mastectomy, with or without supplementary irradiation, to conclude that it is not wise or humane to condemn a woman to be treated with these methods," Dr. Haagensen writes. The editorial cites studies that show a greater rate of suvival ten years after surgery among radical mastectomy patients than among patients treated by the lesser surgical methods.

Radical mastectomy was first perfected more than 75 years ago and has been widely used throughout the world. At Columbia, it has brought a ten-year survival rate of 68 per cent as compared to 60 per cent for the less drastic methods. These percentages are in patients whose disease had not progressed beyond the tissue removed by surgery.

"These differences may seem small, but the numbers of cases are sufficiently large to make them significant. I can say that in doing the radical mastectomy on approximately 1,000 patients during my lifetime, I will have achieved ten-year survival in some 75 patients who would not have reached it if I had been content with the modified operation. It has cost me approximately 3,000 more hours of time in the operating room, but looking back I consider the time well spent."

Gas-producing infections of the bladder are rare and may produce a syndrome suggestive of intestinal obstruction.

Cystitis Emphysematosa

A Report of Two Cases

Milton E. Landman, M.D.,
Fidel A. Aguirre, M.D., et al./Bloomfield*

Two cases of cystitis emphysematosa were seen within a short time at St. Vincent's Hospital in Montclair. One simulated bowel obstruction and the importance of the differential diagnosis (both clinically and radiologically) make it worthy of reporting in the medical literature.

Cystitis emphysematosa is a rare cause of gas in the bladder. More commonly, gas is caused by a vesico-colic or vesico-vaginal fistula associated with infection or neoplasm. These were ruled out in our cases. Primary pneumaturia is a result of an infection with gas-forming bacteria, most commonly E coli or Aerobacter aerogenes. Greatest incidence is in diabetics because of their susceptibility to infection and because some strains of bacteria form gas from glucose.

Case One

A 66-year-old man was admitted with lower abdominal pain and distention progressive for several days. Cramping pain in the lower abdomen, intermittent but increasing in frequency and severity, had been noted for several weeks. No bowel movement had occurred in two days. He had been a diabetic for thirty years, receiving 250 milligrams of chlorpropamide daily for ten years. He had severe coronary heart disease. He had received methenamine over a period of time for chronic urinary tract infection. He had a rounded mass filling the pelvis and extending to the umbilicus. This mass was tympanitic to percussion. The abdomen was quiet to auscultation. Temperature was 100. Rectal examination showed a 3 plus enlarged prostate. Flat plate of the abdomen revealed a large distended gas-filled shadow occupying the pelvis and lower abdomen. It had a scalloped appearance simulating large bowel haustrations. Because of the bizarre position and appearance of the gas-filled shadow, catheterization was done with the passage of large amounts of foul smelling gas along with reddish cloudy urine. With catheterization, the mass disappeared and the abdomen seemed normal. Urine showed 3 plus albumen. It was cloudy and had innumerable RBC and WBC. Cultures showed E Coli sensitive to most common antibiotics. Ampicillin was started.

Barium enema, small bowel and upper gastrointestinal series were done to rule out fistuli. Intravenous pyelogram showed poor dye excretion. Cystoscopy revealed a massively dilated inflamed bladder without fistula. A trilobed prostatic obstruction was noted. Oral charcoal test also failed to show fistula. Transurethral prostatectomy was done but the patient died several days later of cardiovascular complication.

Case Two

A 66-year-old woman was admitted with four days of gross hematuria. She had been a diabetic for ten years, treated with diet alone. She had had recurrent bouts of urinary tract infection. Hysterectomy for



Figure 1, Case One—Large radiolucent gas pocket with scalloping in its border. This pouch appears mainly in the midline extending from the pelvis into the lower abdomen.

*Co-authors are O. G. Caprio, M.D., and R. Russomanno, M.D.



Figure 2, Case One—The rectum is seen outlined with feces projecting in the lower portion of the large gas pouch in the lower abdomen and pelvic cavity.



Figure 3, Case One—No fistula is demonstrated between the large bowel and distended urinary bladder with gas.



Figure 4, Case One—IVP reveals poor functioning of the kidneys. Contrast media (hypaque) is seen in the urinary bladder. Some bubbles of gas are seen within the urinary bladder. This examination was done after catherization of the urinary bladder. Large amount of gas was expelled.

fibroid tumor had been done eighteen years previously. Her current blood pressure was 200/98. Tenderness in the suprapubic area without mass was noted. Urine was grossly bloody with innumerable red and white cells. Two urinary cultures showed klebsiella enterobacter species. A flat film of the abdomen showed only a few bubbles of gas in a crescentic shaped distribution above the pubic symphysis. Intravenous cystogram showed translucent gas bubbles surrounding the wall of the urinary bladder. These bubbles changed with different positions of the patient. No obstructive uropathy was demonstrated. Cystoscopy indicated acute and chronic hemorrhagic cystitis. Upon insertion of cystoscope large amount of foul smelling gas was emitted. The wall was edematous with gas-filled bullae and blebs. The patient was treated with ampicillin and discharged much improved.

Cystitis emphysematosa generally is suspected from the cystoscopy but in our first case the diagnosis was suspected from the clinical findings and the flat film of the abdomen. This showed a large well-outlined pocket of gas suprapubically. A typical x-ray is shown from another case seen at Martland Hospital. In some cases (Case Two) only a few bubbles of gas in a crescent-shaped area of the urinary bladder are noted. Changing the position of



Figure 5—This film from Martland Hospital (New Jersey Medical College) in a diabetic patient shows well outlined, distended urinary bladder with gas due to gas-forming bacteria.

the patient is helpful. Occasionally the patient gives the history of passing gas from the bladder while urinating. In all diabetic patients with unusual gas patterns in the lower pelvis the possibility of cystitis emphysematosa should be suspected. Confusion with bowel obstruction may be a real consideration. Extensive renal and perineal emphysema have also been reported in diabetic infections with gas-producing bacteria.



Figure 6, Case Two—The urinary bladder appears distended with gas mixed with contrast media (urogram).

Summary

Two cases of gas-producing infection of the bladder with interesting features are presented. The possibility of confusion with intestinal obstruction is discussed.

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Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (> 5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

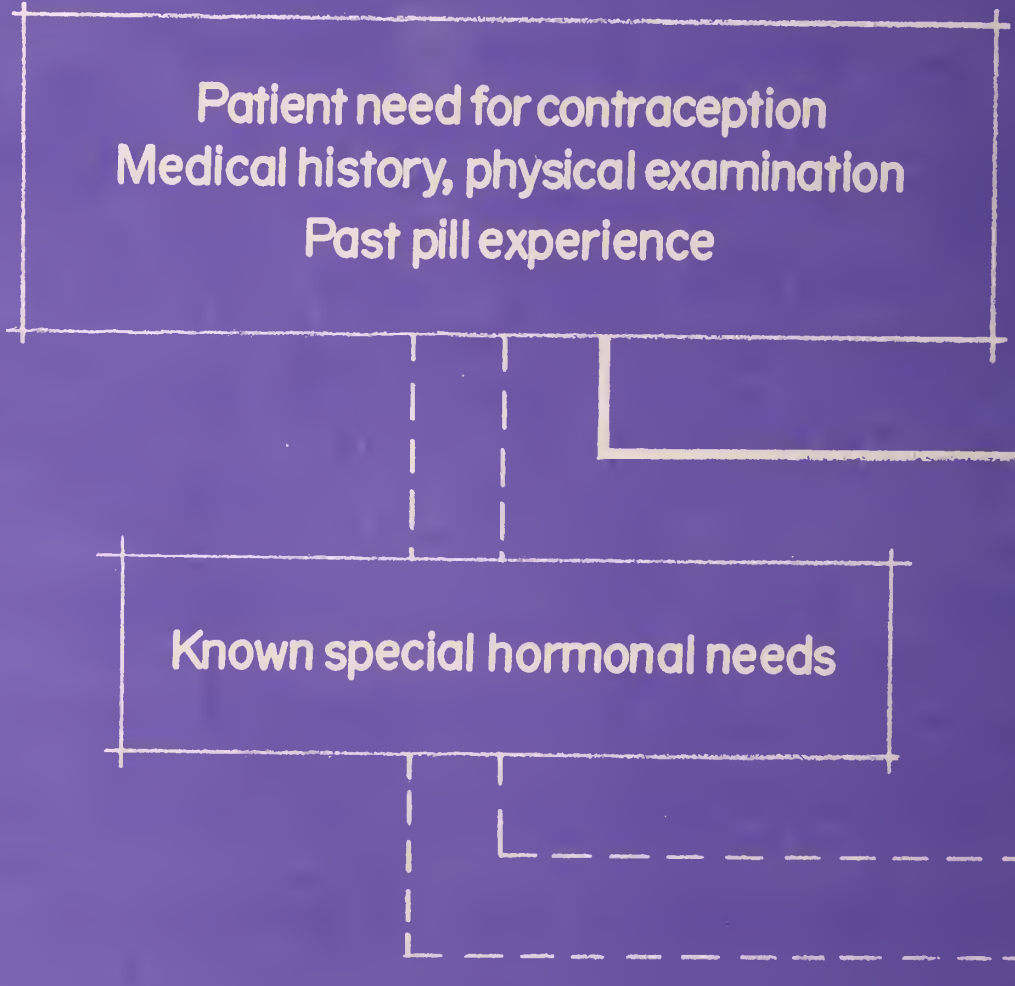
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Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in the United States. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factc such as epilepsy, migraine, asthma, cardiac or renal dysfunctio require careful observation. In breakthrough bleeding, and in a cases of irregular bleeding per vaginam, nonfunctional caus should be borne in mind. In undiagnosed bleeding per vagina adequate diagnostic measures are indicated. Patients with a hi tory of psychic depression should be carefully observed and th drug discontinued if the depression recurs to a serious degree. Ar possible influence of prolonged Ovulen or Demulen therapy on pit itary, ovarian, adrenal, hepatic or uterine function awaits furth study. A decrease in glucose tolerance has been observed in a si nificant percentage of patients on oral contraceptives. The mec anism of this decrease is obscure. For this reason, diabetic patien should be carefully observed while receiving Ovulen or Demule therapy. The age of the patient constitutes no absolute limiting fa tor, although treatment with Ovulen or Demulen may mask th onset of the climacteric. The pathologist should be advised Ovulen or Demulen therapy when relevant specimens are submi ted. Susceptible women may experience an increase in blood pre sure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contrace tives—A statistically significant association has been demonstrate between use of oral contraceptives and the following serious a verse reactions: thrombophlebitis, pulmonary embolism and cer bral thrombosis.

Although available evidence is suggestive of an association, suc a relationship has been neither confirmed nor refuted for the fc lowing serious adverse reactions: neuro-ocular lesions, e.g., retin thrombosis and optic neuritis.

The following adverse reactions are known to occur in patien receiving oral contraceptives: nausea, vomiting, gastrointestin symptoms (such as abdominal cramps and bloating), breakthroug bleeding, spotting, change in menstrual flow, amenorrhea durir and after treatment, edema, chloasma or melasma, breast change (tenderness, enlargement and secretion), change in weight (i crease or decrease), changes in cervical erosion and cervical secr tions, suppression of lactation when given immediately post partun cholestatic jaundice, migraine, rash (allergic), rise in blood pre sure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported i users of oral contraceptives, an association has been neither co firmed nor refuted: anovulation post treatment, premenstrual-lik syndrome, changes in libido, changes in appetite, cystitis-like sy drome, headache, nervousness, dizziness, fatigue, backache, hi sutism, loss of scalp hair, erythema multiforme, erythema nodosun hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of or contraceptives: hepatic function: increased sulfobromophthalein r tention and other tests; coagulation tests: increase in prothrombi Factors VII, VIII, IX and X; thyroid function: increase in PBI an butanol extractable protein bound iodine, and decrease in T^3 u take values; metyrapone test and pregnanediol determination.

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Many systemic and general diseases may first manifest themselves by rectal and anal symptoms.

Anorectal Manifestations of Systemic Disease*

Joseph A. Scoma, M.D./La Jolla, Calif.

Any physician who in the course of his practice examines the anus and rectum should have a firm knowledge of the normal appearance of that area. However, he should be familiar not only with the obvious pathology (such as abscesses, fissures, and fistulas) but also with what they may represent in terms of the patient's systemic problems. Most anorectal diseases are not of a systemic nature, but when they *are,* the astute examiner may ultimately benefit the patient much more than by the local treatment of the presenting problem. Proctologic examination may present the clue to the basic diagnosis which may not only make the treatment of the anorectal disease more successful, but may in fact make the treatment of the other as yet unrecognized diseases possible. In this paper a few of the more common systemic diseases that may manifest themselves in the anorectum will be described.

Tuberculosis—Tuberculosis of the anorectum is rare. When found, it is usually secondary to a focus in the lung or intestine. In its most common form it presents as an anal ulcer that is soft, shallow, and uneven with bluish or pink undermined edges. Rather than being posterior or anterior the tuberculous ulcer is usually lateral and appears indolent. The base is covered with a necrotic mucopurulent debris that is frequently foul-smelling. Tiny yellow tubercles may be seen in the base. Despite the usual conservative modalities of treatment the ulcer becomes bigger. Diagnosis is made by biopsy alone or combined with the history, sputum examination, and chest x-ray.[1]

Gonorrhea—With the increasing incidence of gonorrhea among the teenagers and young adults, gonorrheal proctitis is becoming more prevalent. Most cases will occur in homosexuals. Bacon[2] tells us that rectal intercourse may not be the only means of acquiring this disease. Gonorrhea may affect not only the urethra but the eyes and joints as well. Reiter's Syndrome is a well-known entity characterized by arthritis, iritis, and urethritis.The epidermis must be quite resistant because the anus is rarely involved. Usual involvement is of the lower three inches of the rectum. The mucosa appears acutely inflamed, edematous, and dark red. A thick, creamy layer of pus with a pungent odor may be present. The constant discharge of pus may result in perianal excoriation with itching, burning, and fissuring. In neglected cases, multiple ulcers might be seen especially on the anterior wall of the rectum. A patulous anal orifice with the findings mostly anterior should make us suspect the etiology of the proctitis and the explanation for the joint and ocular complaints. A simple culture or Gram stain will confirm the diagnosis.

Syphilis—Syphilis in the United States is again increasing and like gonorrhea it may first be suspected and diagnosed by the proctologist.

*Read before the Sections on Gastroenterology and Proctology, General Practice, and Medicine, 207th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 14, 1973. This work is from the Muhlenberg Hospital in Plainfield where Dr. Scoma was then associated.

In the anorectum, syphilis may be seen in any of the three stages but is most commonly noted in its primary stage as a shallow ulcer. The ulcer or fissure is usually painless and lateral. The borders are elevated and rose colored while the base is gray. The fissure fails to respond to the usual treatment and in 3 to 4 weeks it is larger and inguinal nodes can be palpated and may be found tender. A darkfield study will show the spirochetes. The Wasserman and VDRL may be negative in the early stages of the luetic fissure.

In the secondary stage, luetic condyloma may be present. The possibility of syphilis must be kept in mind whenever we find condyloma of the anal region since not all condyloma are of the simple acuminata type. They begin as rounded, pearly-white patches that seem to multiply and surround the anus, becoming covered with a grayish, foul-smelling exudate. Itching and staining may be presenting complaints.

In the tertiary stage, gummata are found appearing as round, smooth, movable, submucosal pea-like masses that may enlarge to the size of a golfball and ulcerate with resultant profuse discharge and bleeding.

In the late stages when there are no mucocutaneous manifestations of syphilis, the central nervous system may be involved resulting in an ataxic sphincter mechanism. The anus is found to be patulous, closing very slowly after a digital examination. After sigmoidoscopy it may remain open and allow visualization of the rectum. The appearance is that of a sphincter paralyzed by local infiltration anesthesia. The patient's only complaint might be that of mild incontinence and/or constipation.

Crohn's Disease—Transmural colitis, transmural enteritis, regional ileitis, or granulomatous colitis is a chronic inflammatory disease of the small and/or large bowel of unknown etiology that is being recognized with greater frequency. It usually affects men and women in the first two decades of life and is characterized by intermittent crampy abdominal pain and diarrhea without blood. In time there may be intestinal obstruction, perforation with abscess formation and fistula formation. Almost 50 per cent will require surgery for these complications. A third will have anorectal manifestations that may lead to the proper diagnosis long before its true nature is suspected.

Crohn's Disease should be suspected in any patient between the ages of 6 months and 25 years of age who has an anal fistula.[3] A small bowel series should be routinely ordered on these patients and treatment of any fistulas deferred[4] until this study has been made. The fistulas may be "unusually complex having many side channels or multiple secondary openings."[5] The perineum may appear extensively wet, red, and thickened. Postoperative wounds heal very slowly and appear indolent. Lateral fissuring with chronic skin changes may be present. "When digital-rectal examination elicits pain out of proportion to expectations and the examiner feels a thickening of the integument of the anal canal the presumptive diagnosis of regional ileitis can be made, especially if these findings are accompanied by a compatible history of diarrhea or cramps after eating."[5]

On proctosigmoidoscopic examination, there are longitudinal ulcers of varying sizes with asymmetric distribution. Between these "rake ulcers" is normal appearing mucosa that may have the appearance of "cobblestones" due to the underlying edema. This patchy distribution differentiates Crohn's colitis from nonspecific ulcerative colitis.

Chronic Ulcerative Colitis—Ulcerative colitis is an inflammatory disease of the large bowel characterized by episodes of bloody mucopurulent diarrhea. It is of unknown etiology but unlike Crohn's Disease it is only a mucosal disease. It may manifest itself in a variety of systemic disturbances including arthritis, clubbing, skin rashes, ocular disturbances and hepatic disease. Anal disease is relatively unusual but the proctoscopic findings are the basis of the diagnosis.

In most cases, the disease begins and is most easily recognized in the distal rectum. About one-third will have a completely normal barium enema. On proctoscopic examination, the mucosa appears diffusely inflamed or ulcerated. A mucopurulent film may be present. Diagnosis can frequently be made on anoscopy by finding a uniform, symmetrical inflammation of the rectum. The mucosa appears edematous, granular, and is friable. Gentle swabbing with a cotton-tipped applicator stick will result in fine punctuate bleeding points. In the chronic, quiescent form regenerative mucosa may give the appearance of extensive polyp formation or "pseudopolyposis."[5]

Amebiasis—Amebiasis is an endemic disease of Latin America caused by Entamoeba histolytica. As more Americans travel to places such as Mexico and South America, amebiasis will become more common in the United States. The tissue form of the disease results in granulomas and abscesses with the liver, lung, spleen and brain being involved. According to Bacon[2] abscess formation with hepatitis occurs in about 22 per cent and has a poor prognosis.

The infection usually begins with the sudden onset of profuse, watery diarrhea associated with colicky lower abdominal pain. There may be 20 to 30 stools a day with fever, malaise, anorexia, nausea, and vomiting. Dehydration, electrolyte depletion, and prostration may result. In the chronic states there may be intermittent diarrhea and constipation with the patient noticing these symptoms for years after the acute onset of diarrhea. On sigmoidoscopy you will see discrete ulcers throughout the rectum and rectosigmoid with normal mucosa in between.[6] On occasion, granulomas will be noted. The trophozoites burrow their way through the mucosa into the submucosa and in so doing leave necrotic debris. Many of the ulcers may have white caps. Once this cap or plug is wiped away, the typical ulcer is noted. Throughout the mucosa might be seen tiny yellowish-white dots representing the beginning of the amebic ulcer. Because the disease affects mostly the submucosa the edges of the ulcers will appear overhanging and elevated and may even give the appearance of multiple mucosal tags. In advanced cases, these ulcers can coalesce giving the appearance of a huge rectal fungoid ulcerated lesion resembling a carcinoma. Examination of fresh smears of the rectal secretions or the base of a typical ulcer should confirm the diagnosis. At times, a biopsy of a rectal valve may be necessary to substantiate the diagnosis.[7]

Diabetes Mellitus—Diabetes affects at least 2 per cent of the population or 4 million Americans and in some 40 per cent of these, the disease is as yet unrecognized. It is ten times more prevalent in patients over 45 than in those below this age.[8] The earliest manifestation of the disease may be in the perianal area. Recurrent anal abscesses (particularly when no fistulous tract can be found) and anal abscesses occurring in different anal quadrants of the same patient should make us suspicious. When the abscess cavity closes slowly after adequate drainage, diabetes is suspect. Very large abscesses are also more common in diabetics. An elderly patient who develops a second or third anal abscess, each in a different anal quadrant who does not respond promptly to adequate drainage but runs a febrile course and appears toxic, most likely has diabetes. Perianal itching may also be due to diabetes, although most cases of pruritis ani are idiopathic, some may be due to diabetes and will respond to local treatment only when the underlying disease is brought under control.

Hematologic Disorders—Many blood dyscrasias may manifest themselves in the anorectum. They are, for the most part, more serious than the presenting problems.[9, 10, 11] Patients with leukemia are not only more likely to develop anal abscesses but they can become quite septic. Similarly, patients with aplastic anemia who are lacking a normal defense mechanism may become very toxic from a relatively small area of suppuration. In our series, one in two hundred patients with an anal abscess was found to have leukemia.[4] Leukemics on chemotherapeutic agents are

particularly susceptible to infection and when it develops it may be the direct cause of death. On proctoscopy leukemic implants can occasionally be seen in the submucosa and these tiny, yellowish nodules may go on to ulceration and bleeding. In a patient who presents himself with severe anal pain out of proportion to the area of suppuration present, leukemia should be suspected and incision and drainage should not be done unless leukemia is ruled out first. Incision and drainage of an abscess in a leukemic patient will frequently result in a massive slough of the perianal area.[12]

Persistent and severe bleeding in a patient with minimal hemorrhoids may be due to one of the coagulopathies. A thorough history including family history and dental history will usually help to determine a bleeding disorder. These disorders include leukemias, idiopathic thrombocytopenic purpura, aplastic anemia, Von Willebrand's Disease and the hemophilias. When the usual treatment, with suppositories, rubber band ligation, and careful surgery, fails to control the bleeding, a blood disorder is likely.

Actinomycosis—This fungal infection may affect the lungs but is also seen in the skin as fistulous branching tracts of a chronic indolent nature. These burrowing sinus tracts are most commonly noted in the neck, thorax, and abdomen but may be seen in the perineum where along with tuberculosis and Crohn's Disease they should be considered in the differential diagnosis of an anal fistula. On examination of the perineum, multiple openings may be seen widely separated from each other and quite distant from the anus. Because of their atypical locations they may be confused with pilonidal sinus tracts. The diagnosis is based on suspicion, culture, and the identification of the characteristic ray fungus with sulfa granules in the discharge.

Other Systemic Diseases—Among these are the central nervous system disorders such as the neuropathies and spinal cord tumors but particularly multiple sclerosis that may first present with sphincter disturbances. Huge bleeding internal hemorrhoids appearing to extend unusually high on proctoscopic examination may suggest portal hypertension as in Laennec's cirrhosis. An unusually dry anus, poor sphincter tone, and a very large rectal ampulla may be indicative of hypothyroidism and finally soft, yellowish submucosal and subcutaneous deposits in the rectum, anal canal, and perineum may be due to the lipid storage diseases such as hyperlipidemia.

Summary

Examination of the anorectum may present clues to systemic diseases not as yet ascertained. It behooves those of us engaged in examining the anorectum to be aware of these rather unusual presentations so that the patient may be more appropriately treated. In this article some of these diseases have been described.

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Recommendations† on Combination Live Virus Vaccines

American Academy of Pediatrics

Committee on Infectious Diseases

In the September 15, 1971 *AAP Newsletter* sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."



United States Public Health Servic

Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidit and Mortality Weekly Report*, the Advi ory Committee on Immunization Pra tices of the United States Public Healt Service presented recommendations o the use of combination live virus vaccine The committee stated that:

- "Data indicate that antibody respons to each component of these combinatio vaccines is comparable with antibody re sponse to the individual vaccines give separately.
- "There is no evidence that ad verse reactions to the combine products occur more fre quently or are more sever than known reactions to th individual vaccines (see pe tinent ACIP recommenda tions).
- "The obvious convenienc of giving already selecte antigens in combined forn should encourage considera tion of using these product when appropriate."

†For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

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MSD suggested immunization schedule for well babies

Age	Vaccine(s)
2 months	DPT (diphtheria-pertussis-tetanus) Oral poliomyelitis vaccine (triple)
3 months	DPT[1]
4 months	DPT Oral poliomyelitis vaccine (triple)
6 months	Oral poliomyelitis vaccine (triple)
12 MONTHS	**M-M-R (MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE, MSD)**

This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.

ince vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and ie vaccine should not be given during the same office visit.

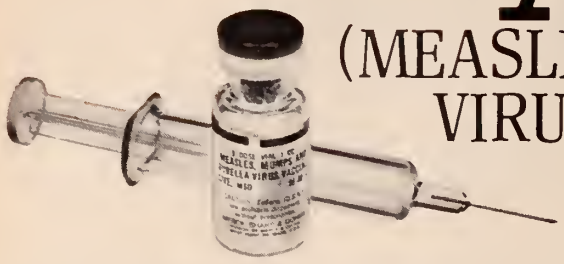
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No untoward reactions peculiar to the combination vaccine (M-M-R) have been reported.

Moderate fever (101–102.9 F) occurs occasionally. High fever (over 103 F) occurs less commonly. On rare occasions, children who develop fever may exhibit febrile convulsions. Rash (usually minimal and without generalized distribution) may occur infrequently.

Since clinical experience with measles, mumps, and rubella virus vaccines given individually indicates that very rarely encephalitis and other nervous system reactions have occurred, such reactions may also occur with M-M-R. A cause and effect relationship, however, has not been established.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Must not be given to women who are pregnant or who might become pregnant within three months following vaccination.

Contraindications: Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

Precautions: Administer subcutaneously; do not give intravenously. Epinephrine should be available for immediate use should an anaphylactoid reaction occur.

Should not be given less than one month before or after immunization with other *live* virus vaccines; vaccination should be deferred for at least six weeks following blood transfusions or administration of more than 0.02 cc immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles and mumps vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2–8 C (35.6–46.4 F) and protect from light. Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2–8 C (35.6–46.4 F), and discard after eight hours.

Adverse Reactions: Fever, rash; mild local reacti such as erythema, induration, tenderness, regic lymphadenopathy; parotitis; thrombocytopenia purpura; allergic reactions such as urticaria; arthr arthralgia, and polyneuritis.

Occasionally, moderate fever (101–102.9 F); less c monly, high fever (above 103 F); rarely, febrile c vulsions.

Encephalitis and other nervous system reactions t have occurred very rarely with the individual vacci may also occur with the combined vaccine.

Transient arthritis, arthralgia, and polyneuritis features of natural rubella and vary in frequency severity with age and sex, being greatest in adult males and least in prepubertal children. Such re tions have been reported with live attenuated rub virus vaccines. Symptoms relating to joints (p swelling, stiffness, etc.) and to peripheral nerves (p numbness, tingling, etc.) occurring within appr mately two months after immunization should be c sidered as possibly vaccine related. Symptoms h generally been mild and of no more than three da duration. The incidence in prepubertal children wo appear to be less than 1% for reactions that wo interfere with normal activity or necessitate medi attention.

How Supplied: Single-dose vials of lyophilized v cine, containing when reconstituted not less tl 1,000 $TCID_{50}$ (tissue culture infectious doses) measles virus vaccine, live, attenuated, 5,000 $TCID_{50}$ mumps virus vaccine, live, and 1,000 $TCID_{50}$ of rube virus vaccine, live, expressed in terms of the assig titer of the NIH Reference Measles, Mumps, and l bella Viruses, and approximately 25 mcg neomyc with a disposable syringe containing diluent and fit with a 25-gauge, 5/8" needle. Also in boxes of 10 sing dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

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Here reviewed are 237 cases of inversion injuries of the ankle treated conservatively with excellent results. Two to ten-year follow-up supports the procedures.

Inversion Injuries of the Ankle

Marvin Chirls, M.D./East Orange

Inversion injuries of the ankle are the most common injury involving any of the joints of the body. Most of these injuries are simple and require minimal treatment. The more severe tears of ligaments surrounding the lateral aspect of the ankle must be treated with great care to prevent lasting sequelae. These ligamentous injuries may be classified as: (1) Sprains with tearing of ligaments without instability and (2) instability of the ankle from severe sprain or dislocations.

This paper will be confined to ankle injuries which are unstable, but without dislocation. The lesion is often missed by the initial examiner. The patient is seen in the emergency room of a hospital, roentgenograms reveal no fracture or dislocation with some soft tissue swelling and the case is dismissed as a sprained ankle.

I am here reviewing a series of 237 patients treated from 1960 to 1970 with a follow-up from two to ten years. These patients ranged in age from 16 to 54 with a mean of 32. All modalities of diagnosis were used from physical examination to roentgenograms and contrast dye arthrography.

The easiest classification of this type of injury that has been devised is a simple sprain or a major ligamentous tear with instability. Treatment has been based on the difference between these two conditions.

A review of the literature[1] reveals the treatment of these injuries to the lateral collateral ligaments of the ankle to be anywhere from injection of local anesthetics to operative repair of ligamentous structures. The importance of injuries to the lateral collateral ligaments of the ankle was brought out by Leonard[2], by Jones,[3] and by Bonin[12].

Leonard[2] reviewed 51 cases of inversion injuries of the ankle. He noted that in his 23 patients treated with six weeks of plaster encasement, all were free of symptoms after this period of immobilization followed by two or three weeks of strapping.

Percy, Hill and Callaghan[1] felt that prompt surgical repair of complete tears was indicated in young athletes. Bonin[14], who in the past favored conservatism, now recommends surgical repair for young active people with unstable ankles.

Mullins and Sallis[4] placed a screw across the tibio-fibular ligament anteriorly and state that in 75 per cent of these cases treatment was successful. Whether this is due to postoperative immobilization in plaster or the screw itself leads one to question the results. The studies of Brostrom[6] would suggest that the instability is between the fibula and the talus not the fibula and tibia.

Most sprains (occurring as they do in inversion) injure the lateral collateral ligaments of the ankle. [9, 10, 11] This lateral collateral complex consists of three main ligamentous structures: the capsule of the joint and the peroneal tendons. The tibio-fibular ligaments and the talo-calcaneal ligaments may also be injured, but they are not included in this series of patients.

The lateral collateral ligaments of the ankle are the anterior talo-fibular, the posterior talo-fibular and the calcaneo-fibular. The patient has difficulty in describing the mode of

injury since it usually happens so fast one does not have time to realize whether the foot is turning in or out or which position the leg has assumed just prior to the accident.

All injured patients in this series were treated in the acute stage. When seen as fresh injuries, evidence of ecchymosis and swelling may be minimal. In the normal foot, the examiner palpates the lateral malleolus, the body and head of the talus and when one inverts the foot the talus remains in contact with the lateral malleolar structures.

In a tear of the anterior talofibular ligament, symptomotology and instability may be brought on with equinus and inversion stress. With a major tear of the anterior talofibular and the fibulocalcaneal ligament, minimal pressure will produce instability. Where there is excessive swelling, ecchymosis, and pain, peroneal and tibial nerve blocks may be in order to examine the patient properly. This can be done as an office procedure along with plain roentgenograms and inversion stress views in neutral position taken with a machine similar to that described by Kleiger[9]. The equinus stress views are performed manually.

Arthrography[7, 8, 9] may be done if one does not feel he can make the diagnosis with stress roentgenograms. This can also be an office procedure with several cubic centimeters of 60 per cent methyl glucamine diatrizoate with or without the concomitant injection of air. When the lateral collateral ligaments and capsule are torn, the contrast medium leaks out below the tip of the fibular malleolus and on its anterior and lateral aspects. If there is any question as to the accuracy of the stress roentgenograms or arthrography then the other ankle is examined at the same time. Arthrograms can be done with and without stress. According to Brostrom[6] a positive stress view is a bonus and a negative stress view is no help in excluding ligamentous instability. This may be true but in my last 100 patients both stress views and arthrography were performed with confirmation of clinical diagnosis and stress films by arthrography.

Two hundred thirty-seven patients with stress instability of the ankle were treated from 1960 to 1970 with a follow-up of from two to ten years. In the follow-up 200 patients could be traced. One hundred seventy-six were examined personally and interviewed. Twenty-four patients merely answered forms sent to them which included the following questions:

1. Do you have any pain?
2. Does the pain occur when walking on uneven ground?
3. Can you localize the pain as to the side or front of the foot?
4. Does the ankle or foot swell, and if so how often?
5. Does the ankle "turn under" frequently?
6. Do you have any difficulty in playing sports?
7. Does change of weather bother you?

All of the patients in this series were treated with non-weight bearing immobilization in a below the knee plaster of Paris bandage for six weeks. Following this a wedge in the sole of the shoe on the lateral aspect measuring ¼ inch was used for an additional four weeks. All patients had stress views ten to twelve weeks from the time of the injury after treatment was completed.

The patients were grouped by function, symptoms, physical findings, and roentgenographic appearance of the joint in those reviewed personally. All "excellent" patients had no complaints, normal function, normal physical examination, and no evidence of calcification in the ligamentous structures on roentgenography. "Good" patients were similar to the excellent group with negative stress films and physical examination but had occasional discomfort with weather changes and rough walking and occasional calcification on the lateral aspect of the ankle. "Poor" patients had chronic complaints of instability and discomfort.

Of the 176 patients examined, four patients were in the "poor" category, six in the "good" category, and 166 were "excellent." All patients who returned the questionnaire said they had an excellent result but I would tend to discount some of these. It may also be that the 37 who did not answer were "poor" but there is no way of determining this.

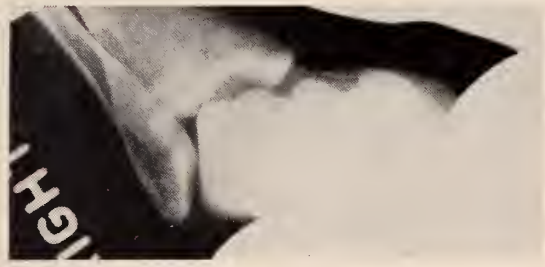


Figure 1—Inversion instability of the ankle on stress views.



Figure 2—Arthrography of the ankle under stress.

Roentgenographically, all "excellent" and "good" patients had negative stress views, but of these, 25 were subjected to plain and stress arthrography. The arthrograms (Figure 2) were not only normal without stress but with it. It is interesting to note these structures involved are self-sealing over a period of years, whereas a "poor" result with instability will show leakage on the arthrogram.

Conclusion

Two hundred thirty-seven patients with inversion injuries of the ankle producing instability were treated conservatively with 176 excellent results.

The follow up arthrograms support the author's treatment and appear to negate the immediate surgical repair for major injuries to the lateral collateral ligaments of the ankle.

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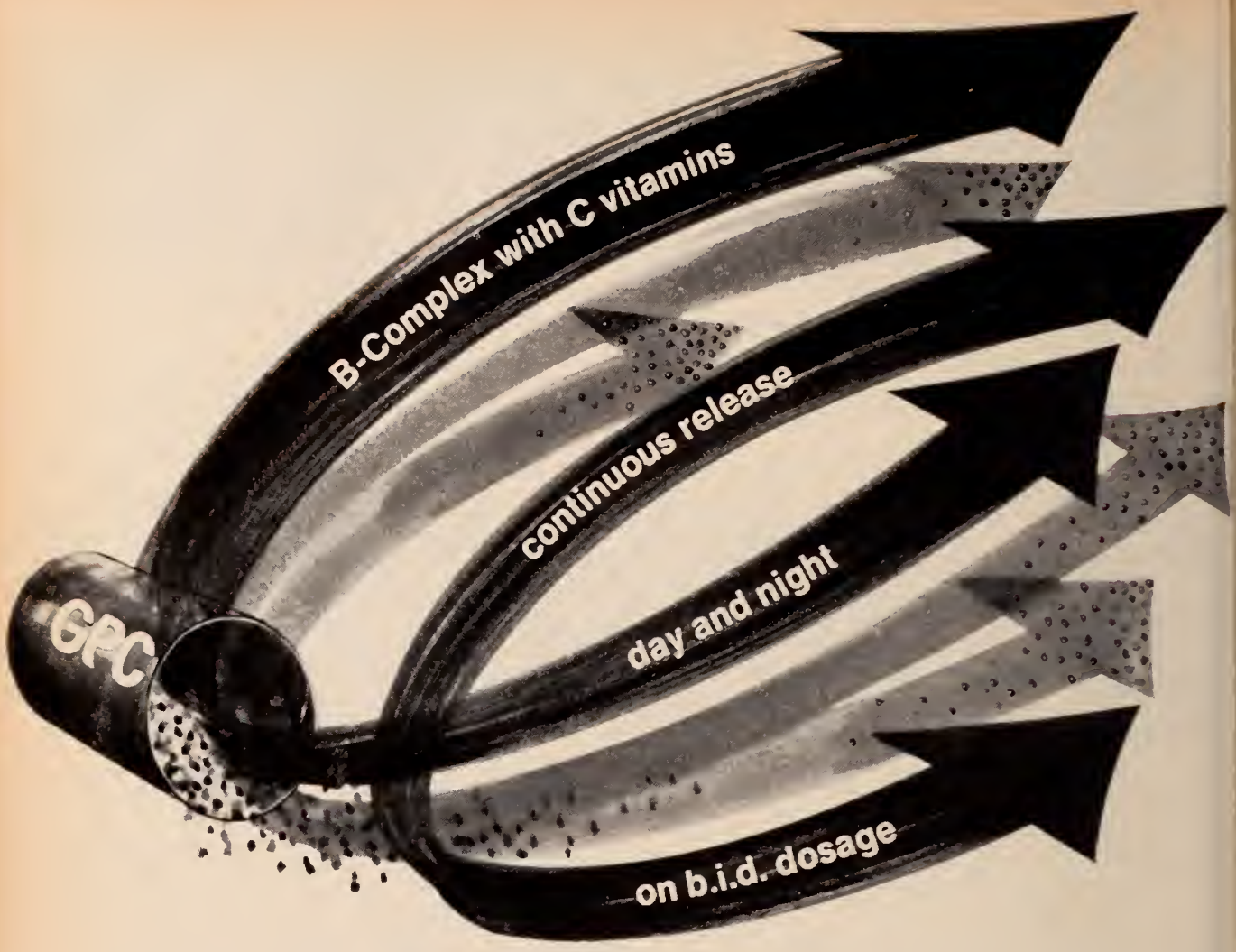
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Pain is the commonest symptom driving the patient to the doctor. Much of this pain is loosely ascribed to "nerves." Dr. Hammer here presents a three-dimensional view of this syndrome.

Psychogenic Pain*

Harvey M. Hammer, M.D./Morristown

The nature of psychogenic pain and its association with or without physical disorders has been the subject of considerable investigation in the field of psychiatry and psychosomatic medicine. Psychogenic pain exists in two categories. The first, as a symbolic expression of an underlying mental conflict residing primarily in that category of psychic disorders known as neurosis. Second, pain has been noted to accompany a number of psychophysiologic disorders relating to underlying psychic conflict. The overlap between these two categories is apparent and in most cases the awareness of the patient in relation to the etiologic factors involving the manifestation of pain is largely unconscious. In psychiatric practice it is interesting to note the need of most patients to deny the psychic origin of their pain. The potential threat involved in becoming aware of the nature of clashes between unacceptable feelings can largely explain the patient's need for denial.

In the area of neurotic dysfunctions, pain manifests itself as a frequent concomitant of two types of disorders. First, pain is frequently seen as a conversion reaction or hysteria. Second, pain frequently manifests itself as a masking symptom for an underlying depression. In the matter of conversion reactions, hysterical neurosis, and depression, the neurotic conflict has found some method of expression by a "leap from the emotional to the physical,"[1] by the somatization of the process. The symptom (in this case, pain) is a symbolic expression in somatic language and a distorted form of the repressed instinctial wish. It is a compromise formation obeying both halves of the complex—the wish and the defense although in hysterical neurosis the former is usually more strongly represented. From a psychodynamic point of view it is thought that the nature of this conflict is closely associated with unresolved feelings of childhood and a fixation or a regression to an earlier state of functioning.

The manifestation of pain in psychophysiological disorders is often encountered in a hospital practice. Walters[2] suggested that this type of pain be called psychogenic regional pain. He suggested that where no peripheral cause of pain can be found and where the pain is regional in site, the psychogenic magnification of actual physical pain should bear that classification. The type of psychogenic pain concerning practicing physicians was found most frequently by Walters[2] to appear in neurologic and neurosurgical practice. Orthopedic practice contributed a significant share of similar problems. Engel[3] noted that some guidelines may be found in the relationship of the pain in psychophysiologic disorders to sexually aggressive and masochistic features of an individual's personality. A patient's conceptualization of how his body functions is an influential factor under the description and manifestation of his pain. As Engel[3] pointed out, for example, "the person who entertains an auto-intoxification theory

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[1] L. Rangell: *Phychosomatic Medicine,* 15:22 (1953) p. 27

[2] Allan Walters: *Brain,* 84.1 (1961) p.2

[3] George L. Engel: *American Journal of Medicine,* 26:899 (1959) p. 984

may get pain relief from cathartics or colonic irrigations, such relief not indicating in any way, colonic disease." Engel[3] further noted that the intensity of pain reported by patients is a highly individual manner. He felt in general that "the more complex the imagery involved in the pain description, the more complex are the psychic processes that are involved in the final pain experience."

Who are in fact the "pain prone" patients? Engel[4] elicited a number of categories which appear to be related to a patient's pain proneness. These were divided as follows:

1. Pain as punishment.

2. Developmental background conducive to the expression of pain as a symptom.

3. Inability of external circumstances to satisfy the unconscious need to suffer.

4. As a response to real, threatened, or fantasied loss.

5. When guilt is evoked by intense aggressive or forbidden sexual feelings.

I would add, as a significant addition to the nature of pain seen in the current population, those patients who are particularly prone to addictions.[5]

From a clinical point of view, where psychic pain is a significant component, secondary psychic pain is equally as important. This pain may take the form of obtaining surcease from the pressures of responsibility, external or internal. It is frequently noted that a period of time, essentially dear and happy to the patient, was "being taken care of" and that he was relieved of the responsibilities associated with that particular time of life. This ability to return to a stage of life where one is being taken care of and is not required to perform physically or psychologically, is paramount. A brief illustration of this follows.

A 17-year-old, attractive, adolescent female was hospitalized for severe low back pain. She was the oldest of five children and was the first member of the family destined to attend college. Her grades in school were excellent and she had been accepted at a number of fine colleges. Over the course of the previous two years the patient's mother had been disabled rather consistently by persistent symptoms of low back pain. The patient, at this point, assumed most of the household duties. Six months before the manifestation of her low back pain she began to act out sexually. A massive denial of guilt or of anger was characteristic during all the psychiatric interviews. Physical findings did not suggest organic diseases. The patient, despite her persistent pain, managed to leave for college. Within six months she had persuaded a neurosurgeon to do a laminectomy. The patient returned home and appeared to have obtained significant relief of her symptoms. Six months thereafter, she was once again strongly encouraged by her family to attend college and to assume the responsibilities and activities concomitant with her age. Several weeks later she developed a return of pain of the same intensity and in the same region. It was only after a six months course of psychotherapy combined with hypnotherapy that the patient was able to express her very conflicted feelings and was able to relinquish her painful symptoms. This patient continues to function at the college level in a pain-free fashion.

The longer the symptom remains, the greater the secondary pain involved, the more difficult effective treatment will be. As Engel[6] has pointed out, a physician following two simple principles will be in a positive and advantageous state. First, permitting the patient to talk freely and taking seriously what the patient has to say, is essential. If, in addition, the physician has some understanding of the nature of psychic pain and its psychodynamic ramifications, a further advantage will be obtained. Rangell[7] pointed out that the treatment of psychic pain should entail both symptomatic and specific therapies. He advocated a variety of methods including drug therapy and analgesics, placebos, surgical measures, electroshock therapy, occupational therapy, and, of course, psychotherapy. It was Rangell's[7] feeling (and representative of general psychiatric thought on the matter) that in terms of prognosis, as the degree of psychopathology increases, the successful prognosis decreases. "With an increase in the degree of regression and fixation to earlier emotional genetic levels of development the prognosis becomes more ominous."[8] From my own point of view the most effective treatment has occurred when a close coordination is obtained between the psychiatrist, the attending physician, and the patient's family. I have utilized

[4] George L. Engel, *op. cit.* p. 916

[5] L. Rangell, *op. cit.* p. 30

[6] George L. Engel, *op. cit.* p. 918

[7] L. Rangell, *op. cit.* p. 35

[8] *Ibid.* p. 36

with good success, the various modalities of treatment mentioned. Sodium Amytal® interviews in conversion states have been especially effective. Mood elevating drugs and anxiety reducing drugs have been effective in patients suffering from depressive and anxiety states. Behavioral therapy and reciprocal inhibition therapy have shown increasing popularity of late and offer further alternatives.

Summary

A discussion of the types of psychic pain frequently seen in clinical practice has been presented. Some clarification of the functional determinants of psychic pain has been discussed. Special attention has been paid to the "pain prone" patient, clinical therapeutic technics, and an assessment of prognosis and treatment modalities.

52 Maple Avenue

Shock Treatment Unit in Newark

One of the first shock units in New Jersey is at Martland Hospital in Newark, under the College of Medicine and Dentistry of New Jersey—New Jersey Medical School. The shock team has been in operation for about one year.

Next to the physicians themselves the primary mechanism of the shock unit is a special monitoring device that can read-out six life-functions on a constant or instantaneous basis. The average monitor usually incorporates two parameters, mostly electrocardiogram and blood pressure. The new monitor reports EKG, intra-arterial blood pressure, pulse, temperature, cardiac output, blood pressure in the lungs, and other special measurements concerning breathing which are not ordinarily obtainable.

The Martland shock team was established with the aid of a grant from the National Institutes of Health. Resident physicians are on call 24-hours a day and in cases of emergency can mobilize their monitor in a half-hour.

All trauma victims receive immediate attention in the hospital emergency room and by the on-duty surgery team. Any internal bleeding causing shock is usually found and stopped by the surgeons. However, if the patient doesn't respond to surgery, a member of the team is called in to monitor the patient. He will stay with the patient until the complication is corrected.

Trauma is the number one cause of death of persons aged one through 35, and speedy treatment can usually be responsible for allowing a young person to walk out of the hospital recovered. Presently 12 per cent of all hospital beds are filled with trauma patients.

Though the present set-up with the single multichannel monitor has been sufficient thus far, the physicians are looking forward to integrating a currently available computer for further processing of data. "Once we work the computer into the system we will add more parameters to the six standard monitors in our intensive care unit. These monitors will be connected to the computer," the unit chief explained, "which will analyze the data and serve as our write-out device. At that time we will be able to handle more patients with the same thorough care with which we can now handle only one at a time."

Special care of shock patients has been practiced for only about ten years. It was not until the Korean War that much knowledge of shock was accumulated, and the importance of continuous monitoring in its treatment.

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Diverticula of the appendix are rare: about two instances per thousand that come to surgery.

Diverticula of the Appendix

Robert K. Spiro, M.D., et al./Bloomfield*

The appendix is subject to many diseases, ranging from the very common surgical problem of acute inflammation to the less common, mucocele. The material presented here will deal with diverticula, a disease not usually associated with the appendix. Two cases of inflammation of appendiceal diverticula, one with perforation, will be presented and the subject of diverticula of the appendix discussed.

Case One

A thirty-three-year-old male was admitted to The Mountainside Hospital on April 27, 1965, complaining of diffuse abdominal pain for eighteen hours. At the onset, the pain was diffuse in the abdomen and then localized into the right lower quadrant. He had noted a decrease in appetite the day of illness. He had not been nauseated or vomited. Past history was not unusual and the family history was not pertinent.

He appeared to be a healthy young adult who had no significant physical findings except for right lower quadrant tenderness on examination. Hemoglobin was 15.4 grams, white blood count was 14,500 cells with 77 per cent polymorphonuclear cells. A diagnosis of acute appendicitis was made. At operation an acutely inflamed appendix was removed. There was no evidence of peritonitis or perforation. He reacted well to surgery and was discharged from the hospital seven days after admission.

Pathology: Gross examination revealed an acutely inflamed appendix. Diverticula were present in the inflamed distal third which was covered with a fibrinous exudate (Figure 1). Microscopic study revealed the appendiceal and diverticula lumina to be filled with purulent exudate. Mucosal ulceration of both the appendix and the diverticula was present. All walls were infiltrated heavily with neutrophiles in the inflamed section. The appendix and the diverticula were acutely inflamed.

Case Two

A twenty-four-year-old naval serviceman was admitted to The Mountainside Hospital May 23, 1972 with abdominal pain of five days' duration. He had minimized his pain for several days for he was to be married May 28, 1972 and did not wish to cancel his wedding and reception to follow. The pain was mainly in the right lower quadrant. He had no nausea or vomiting. His health had always been good and he had not had this problem before. He was a healthy-appearing adult male. The right lower quadrant was tender to palpation with slight rebound. Temperature was 101.8° and the white blood count was 14.3 thousand cells with 84 per cent polymorphonuclear cells.



Figure 1—The inflammation of the appendix and the diverticulum is evident. Considerable debris is present in the lumina of both. (Magnification—10X)

At surgery, (four hours after admission) generalized peritonitis and an acutely inflamed appendix with perforation were found. The appendix was removed and a drain placed in the McBurney wound. He was supported with intravenous fluids for four days and

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received one gram of ampicillin piggy-backed three times daily. In view of the peritonitis, oral feeding was withheld until the fourth day. At that time 0.5 gram ampicillin, intramuscularly, four times a day, replaced the intravenous. Peritoneal fluid culture showed E. Coli sensitive to ampicillin. SMA 12 on May 25 was normal. All antibiotics were stopped on May 31 and the patient went home entirely well the following day and has remained well.

Pathology: The distal half of the appendix was markedly swollen. Six diverticula were noted. No point of obstruction was present. The meso-appendix was swollen and difficult to separate from the appendix (Figure 2).



Figure 2—A diverticulum entering the mesentery of the appendix is evident. Absence of the muscular coat of the diverticulum is well seen. (Magnification—10X)

Further studies showed multiple diverticula of the mucosa with penetration of the muscularis. Ulceration of the mucosa of some of the diverticula and the appendiceal tissue itself was present. Acute inflammatory cells were heavily present in all layers of the appendix. One diverticulum had necrosis and perforation at one spot (Figure 3).

Appendiceal diverticula are either congenital (true) or acquired (false), and in themselves cause no symptoms. The "true" type is rare and has a complete intestinal wall. In 1968, Favara[1] reported that, as of that date, fewer than forty cases of single congenital appendiceal diverticula had been recorded and only

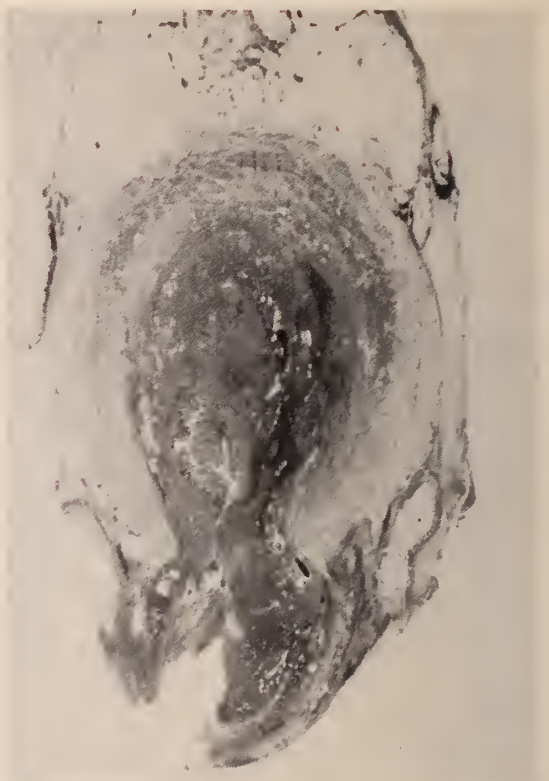


Figure 3—Inflammation of the diverticulum and the appendix is seen. The diverticulum has perforated along the antimesenteric section of the appendix. Both lumina are filled with debris. (Magnification—10X)

five had multiple congenital diverticula. Acquired diverticula are more common and lack a muscular coat and may be single or multiple.

The cause of appendiceal diverticula is not completely known. In 1961, Everts-Suarez and Noteboom[2] reviewed the subject of congenital diverticula. Several theories attempting to explain the pathogenesis of the abnormality were offered. Among the possibilities were that diverticula may represent a second appendix developed from the organ's anlage; may originate from epithelial inclusions in the appendiceal wall; may arise from "local sacculations developed during recanalization of the appendix," during early development.

This latter concept would best explain multiple congenital diverticula. Favara,[1] in reporting three cases of local congenital diverticula of the appendix, suggests there is a relationship between the D_1 trisomysyndrome and the

occurrence of multiple congenital diverticula of the appendix. Acquired diverticula are possibly due to a weak spot in the wall of the appendix adjacent to a blood vessel.[3] It has also been suggested[4] that proximal obstruction with distal increased intraluminal pressure can cause diverticula.[5] Previous infection of the appendix which subsided could cause proximal inflammation and scarring. Anyone in clinical practice is aware of patients having pain in the right lower abdomen suggesting appendicitis which subsides and does not require surgery. The scarring produced subsequently in the area of subsided infection could provide the mechanism for obstruction, distal increased pressure, and the production of diverticula in the future. This would fit in with the thesis noted above by Rabinovitch[4] and Stout[5] concerning a cause for distal increased intraluminal obstruction.

Obstruction may also be due to tumor proximally. The relationship of appendiceal diverticula to mucocele is of interest in this connection. Collins[6] found, in one-fifth of the cases, peritoneal pseudomyxoma and mucocele occur together with appendiceal diverticula. Evans and Murphy[7] state that "the mucin distal to an appendiceal stricture collects into a mucocele and a mucosal diverticulum herniates through a weak point, ruptures, and gives rise to peritoneal pseudomyxoma."

Acquired diverticula may in themselves be the site of infection with or without perforation. They may also be associated with an essentially normal appendix or with an inflamed appendix removed at surgery. An incidence of appendiceal diverticulosis in surgical specimens of 0.33 per cent is reported.[8] Usually the diverticulum is solitary and occurs on the mesenteric side.[8] This will frequently result in a swollen mesentery. On occasion, this appearance may suggest a malignancy.[3,8] Some awareness of the possibility of a perforated appendiceal diverticulum causing the mass will prevent unnecessary extensive surgery for malignancy when appendectomy with or without drainage alone is required, when the situation is encountered.

Preoperative diagnosis of diverticula of the appendix is rare. Radiologic diagnosis is unusual. The five radiologists at this hospital have never personally seen a case on x-ray. Feldman found only one case in 28,000 x-ray studies of the large and small bowel.[9]

The diagnosis of appendiceal diverticula is difficult if there are no specific symptoms. If a diverticulum becomes infected, causing symptoms, the illness usually mimics appendicitis. A significant proportion of patients will report a history of previous attacks of right lower abdominal pain. This may suggest inflammation of appendiceal diverticulum. Average age of patients suffering from inflammation of appendiceal diverticulum is usually greater than patients with appendicitis.[3]

Such facts did not pertain to the patients reported here. The previous attacks may be pertinent, as noted above, to the development of proximal scarring and subsequent diverticula.

Perforation is said to occur earlier in the course of the illness than in the usual case of appendicitis.[3, 4] This suggests the value of the prophylactic removal of an appendix with diverticula when found on routine exploration if no contraindication exists at the time of surgery for another intra-abdominal problem.

Surgical care for inflammation of the appendiceal diverticulum is that for appendicitis in general. The base tie must not in any way include a diverticulum for fear of further problems in the future. The finding of a swollen and inflamed appendix with marked thickening of the mesentery may suggest a diverticulum with perforation into the mesentery. A swollen mass may even suggest a tumor. The value of alertness to this abnormal finding due to a perforation of a diverticula into the mesentery has been commented on before. In the two cases here, diverticula were found both on the mesenteric and antimesenteric side of the appendix. The diverticulum which ruptured was on the antimesenteric side. (Figure 3).

Conclusion

Recent experience at The Mountainside Hospital, Montclair (NJ) with diverticula of the appendix is reported.

In the period between 1964 through 1972, 1,018 surgical appendectomies have been done here. Two appendices of this group had acquired diverticula. Perforation had occurred in one diverticulum. The clinical record and pathology of these cases is reported.

The incidence of diverticula of the appendix at this hospital in surgical specimens is 0.2 per cent, close to the usual figure reported.

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The No-Fault Law and Medical Care

Effective April, 1973, the provisions of the Medicaid Provider Manuals denying payment for that part of benefits covered or payable under any insurance policy have been amended to include benefits payable under an insurance policy covered by the New Jersey Automobile Reparation Reform Act, P.L. 1972, c.70. This will apply to all claims arising out of accidents *occurring on or after January 1, 1973,* which are covered by "No-Fault" insurance policies. The following is a brief explanation of some of the provisions of the "No-Fault" law as well as Medicaid's policy regarding claims submitted in "No-Fault" cases.

Provisions of the "No-Fault" Law—The New Jersey Automobile Reparation Reform Act, which is commonly referred to as the "No-Fault" Law requires that every liability policy insuring an "automobile" shall provide "Personal Injury Protection" (PIP) coverage. The PIP benefits include the payment of all reasonable expenses for medical treatment, surgical treatment, dental treatment, professional nursing services, hospital services, rehabilitation services, x-ray, diagnostic services, prosthetic devices, ambulance services, medication, and other reasonable and necessary expenses resulting from the treatment prescribed by practitioners licensed by the State of New Jersey.

PIP benefits will be paid without regard to negligence, liability, or fault of any kind to the following classes of recipients:

1. the name insured under the "No-Fault" insurance policy;
2. the members of the insured's family residing in his household who sustained bodily injury as the result of a covered accident;
3. other persons sustaining bodily injury while occupying the automobile of the named insured;
4. other persons sustaining bodily injury while using the named insured's automobile with the permission of the named insured;
5. pedestrians sustaining bodily injury caused by the named insured's automobile or struck by an object propelled by or from such automobile.

Under federal regulations, the Medicaid Program is mandated to treat third party liability as a current resource when such liability is found to exist and payment by the third party has been made or will be made within a reasonable time. In this regard it should be noted that a provision in the "No-Fault" Law states that a claim for a covered loss must be paid within 30 days after it is furnished to the "No-Fault" insurance carrier.

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1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

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Adverse Reactions: Consist of mild, transient pain, paresthesias, bleeding and transient dermatitis. Pain usually can be controlled by administration of mild analgesics. Side effects severe enough to warrant discontinuation of therapy occasionally have occurred.

If bleeding or dermatitis occurs as a result of the application of TRAVASE Ointment, therapy should be discontinued. No systemic toxicity has been observed as a result of the topical application of TRAVASE Ointment.

DOSAGE AND ADMINISTRATION: STRICT ADHERENCE TO THE FOLLOWING IS REQUIRED FOR EFFECTIVE RESULTS OF TREATMENT:

1. Thoroughly cleanse and irrigate wound area with sodium chloride or water solutions. Wound MUST be cleansed of antiseptics or heavy-metal antibacterials which may denature enzyme or alter substrate characteristics (e.g., hexachlorophene, silver nitrate, benzalkonium chloride, nitrofurazone, etc.).
2. Thoroughly moisten wound area either through tubbing, showering, or wet soaks (e.g. sodium chloride or water solutions).
3. Apply TRAVASE Ointment in a thin layer assuring intimate contact with necrotic tissue and complete wound coverage extending ¼ to ½ inch beyond the area to be debrided.
4. Apply loose wet dressings.
5. Repeat entire procedure 3 to 4 times per day for best results.

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A coronary care unit can function as a sort of triage station for the emergency room.

The Coronary Care Unit as a Triage Station for the Emergency Room

Jonas Brachfeld, M.D./Willingboro*

Many approaches are being investigated in the attempt to extend the benefit of the Coronary Care Unit (CCU) to the early phases of acute myocardial infarction (AMI). Such projects have included "Life Support Stations," the training of paramedical personnel for emergency squads, and the provision of specially equipped mobile units. These mobile units often report directly to the CCU and bypass the emergency room (ER) entirely. Consequently, patients who are picked up at home by such units are under more constant observation than those who walk into the ER. The latter constitutes a bottle-neck in many programs for early, intensive treatment of the patient with AMI. The hectic conditions prevailing there make it difficult to focus attention on the special needs of these patients and personnel often lacks training to do so.

Programs have provided special training for the ER nurse so that she would feel confident in monitoring and giving emergency treatment, including electric defibrillation, to patients with AMI. In the process, ER personnel have also learned to give priority to such patients who now are made to wait far less and often are placed on monitors as soon as they are found to have appropriate symptoms. The salvage rate of defibrillation and resuscitation in the ER has thus gone up, although it is difficult to obtain relevant statistics. This approach contrasts strikingly with that used in the remainder of the hospital. To increase the salvage rate among patients with AMI "at risk," it has been concluded that it is best to segregate all these patients in a special unit, the CCU. Here the approach has been to improve the training and qualification of the nurses in this unit rather than provide more training to the entire hospital and set up monitors throughout the hospital. It seems illogical, therefore, not to apply the same concept to the patients with AMI in the emergency room who could be expected to have the most recent infarcts and to be, therefore, most highly "at risk." This is especially true in small hospitals where the entire ER staff often consists of only one nurse and a physician. To impose on them the burden of monitoring certain patients being evaluated and awaiting acceptance by a staff physician to CCU may greatly impair their over-all performance. The ER nurse with her many other duties cannot be expected to be as qualified in the provision of emergency cardiac treatment as the CCU nurse, fully committed to this work. The trained CCU nurse, even only with telephone contact with the director of the CCU, will do better than an ER physician who often has primarily surgical training and interest.

Because of these considerations, we started, about a year ago, a pilot project at Rancocas Valley Hospital with the aim of evaluating a

*Dr. Brachfeld is director of the Heart Station at the Rancocas Valley Hospital, Willingboro, New Jersey, and Assistant Clinical Professor of Medicine, Medical College of Pennsylvania, Philadelphia. This material was presented at a meeting of CCU directors by the New Jersey Heart Association on October 8, 1972.

"triage" procedure in the CCU. We were fortunate that this concept evolved at the time of expansion of the hospital. It was decided to build the CCU on the ground floor, only a few feet away from the ER. Patients coming to the ER with chest pain are immediately taken to CCU. Emergency squads bringing in patients with chest pain, or suspected of having heart disease, are similarly directed to take their patients at once to CCU. Strong emphasis is given to reassurance so that the patient is aware that he is merely being evaluated, and that no decision has been reached as to diagnosis. It is pointed out that safety precautions are a matter of prudence, even though his problem may actually be a minor one. Moreover, it is made clear to these patients (and all the records reflect the fact) that they are not being admitted to the hospital but merely placed in a facility that is considered an extension of the ER. The ER physician remains responsible for their evaluation and disposition; he may discharge them to their usual physician, or admit them under the care of a member of the staff but with a non-cardiac diagnosis (in which case they are removed from the CCU). One or two beds are reserved at all times for this "evaluation procedure." If such a patient is thought finally to require admission to CCU he just remains in the bed where he was placed on arrival. If the unit is then filled, another patient is discharged from the unit so that a free bed is available at all times for the "evaluation procedure."

Once a patient is monitored at CCU, the emergency has passed. He can be seen by the ER physician and appropriate studies (such as ECG, portable chest x-ray, or blood work) ordered by the latter. A decision as to the need for admission can then be made either by the ER physician or in consultation with the internist on call. Throughout this time, should dangerous arrhythmias appear, immediate treatment can be given in accordance with standing orders.

Results

In a ten-month period, about 350 patients were screened in the CCU of Rancocas Valley Hospital in this fashion. Of these, 120 were ultimately admitted to the hospital with the diagnosis of either definite or suspected myocardial infarction. Of the 350 patients, eight developed ventricular fibrillation within the first 15 minutes after coming to the ER doors. (This included the very first patient in this "evaluation procedure.") All of these eight patients were successfully defibrillated. In six of these eight, only electric counter shock was required while in the seventh a brief period of cardiac massage was also given. The eighth patient required extensive resuscitative measures, including 25 bouts of counter-shock. He ultimately recovered. All eight patients recovered in the immediate, post-fibrillation period to the extent that they became alert, rational, and lucid and then required no special treatments to maintain cardiac rhythm or blood pressure. Two of the eight died subsequently, one of cardiac rupture and the other of complications attributable to sudden extension of infarction and pump failure. Five others were discharged from the hospital in good condition.

The eighth patient illustrates dramatically the salvage potential of our procedure. He had numerous episodes of ventricular fibrillation on arrival and then almost daily in spite of multiple antiarrhythmic agents. Ventricular premature beats were finally controlled by ventricular pacing ("overdrive"). After one week, he was transferred to a cardiac center (Deborah Hospital, Browns Mills, New Jersey) at 20 miles' distance, under continuous monitoring. He was found to have a ventricular aneurysm, as suspected, and obstruction of only one artery (L.A.D.). Resection of the aneurysm and coronary jump graft were successfully performed. This man had been taken to the CCU and monitored within seconds after arrival at the hospital. He then developed ventricular fibrillation, and optimal treatment could be swiftly administered and the golden opportunity was not wasted.

Admittedly, this small experience has limited statistical validity. However, it is difficult to argue with 100 per cent success. Obviously, the patients presenting to the ER are serious-

ly "at risk" regarding fatal arrhythmias; previous experience at our hospital was far less fortunate regarding salvage. What is more, a heavy burden has been removed from the ER personnel who now can turn their attention appropriately to many other obligations. The initial reaction of great resentment by the ER personnel has now been replaced by relief.

Various CCU directors have objected to this approach, stating that their CCU is already filled as it is and therefore it is not economically feasible to expand it. It would seem that the solution to this problem is not to have an auxiliary CCU in the emergency room; no one will argue that to have two such units in the hospital is far more expensive than one large one. In training ER nurses and in acquiring adequate monitoring equipment for the ER, such a secondary CCU is indeed being set up. A single, adequate unit to house the entire needs of the hospital both for admission and screening is far more economic than two units, one of which is concealed within the total facilities of the ER in order to overcome objections by administration.

Rancocas Valley Hospital

Electrical Hazards in the Operating Room

A plea for greater care in checking electrical devices in hospital operating rooms is voiced in an editorial in the May 28 issue of *JAMA*.

"The life-saving results achieved by a team of skillful surgeons and anesthetists, reinforced by a well-trained team of nurses and operating room personnel, may be nullified by a simple and avoidable accident of a mechanical or electrical nature in the operating room," the editorial says. The author is Zenonas Danilevicius, M.D., one of the editors.

"The most difficult and invisible dangers to the patient lurk in the electrical system of the operating room, in its electrical and electronic equipment." The hazard of static electricity is avoided by use of materials, clothing, equipment, shoes, and flooring material that does *not* conduct electricity.

A danger arises with the use of high-powered electrical equipment, especially for electrosurgery or electrocautery. Cited is a situation in which nine patients suffered burns at the sites of electrocardioscope electrodes within ten months. Causes of the burns were broken ground wires, defective rectifiers, improper equipment, improper use of active electrodes, capacitive coupling of cables, and radio frequency current division.

In one case, the electrocardiographic tracing did not function properly and the connection was transferred from one wall plug to another. The anesthesiologist felt a shock in the hand in checking the patient's pulse, the patient made a sudden jerking movement and the pulse stopped abruptly. The doctor immediately pulled the plug and began first aid. The patient made a full recovery. Investigation revealed that an improperly wired electrocardiographic monitor had been in use for some time. Also, some of the wall sockets in the operating room had reversed polarity.

"Isolated power systems are highly recommended for the patient-care areas in all hospitals. The isolation transformers and the line-isolation monitors are also recommended as a protection against macroshock hazards. Frequent checks of all electrical aspects of the operating rooms by skilled engineer-surgeon teams would be a good measure of protection."



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Special Article

All physicians, but perhaps mostly pediatricians, should find this presentation useful and usable.

The Pediatric Nurse Practitioner in the Private Office

Stanley S. Karp, M.D., Jacqueline Metzler, R.N., and Christian M. Hansen, Jr., M.D., Piscataway

This paper describes the experience of a three-man pediatric practice into which a pediatric nurse practitioner (PNP) was introduced three years ago. This is the first such instance in New Jersey in which a nurse with formal training in a PNP course has functioned in an expanded role in a private setting. It seemed especially appropriate to describe the experience at this time since the first graduates of the first PNP educational program in the State began their practice in public agencies in January 1973.

An informal survey based on the method of Day, Egli and Silver[1] was made in an effort to document the feelings of the patients about their satisfaction with the team of the pediatrician and the PNP. Results revealed a high degree of satisfaction with the care provided by this new team.

The PNP concept was first developed in this country by Silver[1] in 1965 and it has continued to gain acceptance by both the professions. Numerous articles have appeared which have described the acceptance of pediatric nurse practitioners,[1] their role in the office of pediatricians in private practice,[2] their ability to perform accurate physical examinations,[4] and their functioning in an out-patient department.[5]

This describes a three man group serving primarily a middle-class population in suburban Burlington County. It began with one pediatrician nine years ago. Increasing the number of pediatricians did not allow the doctors to care for more patients more efficiently nor did it give them additional time to spend with each patient. There was not enough time for newborn rounds, discharge conferences with mothers, adequate telephone counseling, or for important but nonemergency pediatric problems.

At about the same time that the three pediatricians became interested in the PNP concept, one of the authors (J.M.), a pediatric nurse at a local hospital, enrolled in a PNP program at Massachusetts General Hospital. She wanted the chance to expand her role, to feel a greater sense of accomplishment and to have the opportunity to exercise independent judgment while caring for children.

Prior to this, it was necessary for her to obtain assurance of the promise of a position upon the completion of her course. She obtained this from one of the authors (S.K.) and his colleagues. In February of 1970, she began the Boston program and completed it four months later.

To prepare the patients for Mrs. Metzler, a letter was sent to the patients in the practice explaining the role of the PNP. Preparation of patients contributes to a smoother acceptance of the PNP in any setting and service in private practice. When the PNP began in this office, well-infants were scheduled whose parents would be receptive to the new concept. After the nurse completed her examination, one of the pediatricians was called in for his evaluation. As the nurse became more confident and as the physicians became more sure of her competence, this was found to be unnecessary except when she had a question and needed pediatric consultation.

At first, appointments were scheduled on an alternating basis. The mother would see the PNP on one visit and the pediatrician the next. Some patients indicated that they desired to see her on a continuing basis. As a result, patients were given free choice, within limits, as to whom they would see. One of the reasons many parents were willing to see the PNP instead of the pediatrician was because of their trust that the physician would not have someone incompetent caring for their

children. Another reason was the positive way in which the role of the PNP was introduced to the patient community.

Because of the nurse practitioner's competence in caring for well-children and her skill in differentiating normal from abnormal findings, it soon became obvious that she could manage, in collaboration with the pediatrician, the same children when they became ill. A set of standing orders was developed involving the treatment of various minor illnesses and childhood problems. The pediatrician was always available for consultation and backup.

The care of well-infants and children and the treatment of minor illnesses make up only part of the day of the nurse practitioner. She spends a considerable amount of time in counseling for a variety of childhood problems. She finds it a challenge to provide help which is understood by the parents and which allows them to accept their child's problem.

The PNP provides a preventive health maintenance service and provides a psychological climate which will increase the parents perceptiveness. She tries to increase their creativeness and capacity for dealing with reality rather than increase their dependence on the health professions.

Another important function of the PNP is answering parents' telephone calls. This is an important service, especially since it is provided by someone who is an integral part of the practice and who knows many of the patients well. This function saves the mother from many hours of worry and anxiety waiting for a return call from the busy physician. Since performing this function, the PNP has come to realize the importance of the telephone as a means of communication. She wishes that she had more time to devote to it. Having the nurse provide this function also removes the clerical staff from being put into a position of giving medical advice. The kinds of questions that arise range all the way from the proper dose of aspirin for a child with a fever to such symptoms as vomiting and diarrhea which may indicate more serious disease. The PNP feels that by taking these calls herself and spending time she can pick up clues in the mother's voice which may indicate concern and give a hint of how she is coping with the problem. She has been amazed by how many behavioral, developmental, and emotional problems she has been able to handle over the phone. These are problems that the parents weren't going to call about, primarily because they didn't feel it was important enough to take up the physician's time.

The first contact of the PNP with many families is in the post partum period in the hospital and the newborn nursery where she is involved in making rounds and examining newborns on a daily basis. She introduces herself to the mothers on the first day and spends time with them on subsequent days talking about general principles of newborn care. She points out normal variations such as common skin problems, head molding, tibial torsion, spitting up, and so on. As with the pediatrician, this gives her the opportunity to observe mother and infant interaction which she is able to use in her later contact with the family. She does anticipatory guidance, giving attention to potential areas of concern for the new mother, especially the mother with her first infant. She spends time preparing for the kind of things that they may expect when the infant goes home—problems of sleeping, feeding, crying, and so on. In addition, she makes a telephone call to the family of the new baby within the first two or three weeks after discharge to find if there are any problems which have arisen and which require a home visit.

Other basic functions of the nurse practitioner in this setting are:

1. The detection of disease and deviations from normal in physical and emotional health as early as possible in the infant or small child's life.

2. The initiation of steps toward diagnosis of specific problems and their management in collaboration with the pediatricians.

3. Immunization against common communicable diseases.

4. The promotion of sound nutrition.

5. Education for prevention of accidents and common injuries in early childhood.

6. The fostering of a sound parent-child relationship.

Being a PNP has added a new dimension to the nurse's concept of herself and her concept of nursing. Her relationship with families in times of health and disease have been very satisfying. Functioning as a nurse practitioner presents a daily challenge. Without the special preparation and education of becoming a nurse practitioner and without the proper role orientation, she could not be working with families as closely as she is at the present time. The transition from being a pediatric nurse to a nurse practitioner was a difficult one, and it required time and effort.

The Nurse Practitioner as Viewed by the Pediatrician

The pediatricians here have been impressed with the clinical skill of the nurse practitioner. For example, they feel that her evaluation of the child's ear is at least as good as that of most physicians they know. In one period of six months because of her clinical acumen she diagnosed two cases of congenital hip dislocation, a child with congenital heart disease, and a congenital visual defect in a six-week old infant. However, it is not necessary for her to make a definitive diagnosis as long as she recognizes abnormalities and variations from normal. They often call her in when they suspect some abnormality not only because they enjoy sharing their clinical experiences, but because they have come to appreciate her evaluation of the problem. They feel that the PNP has not only lightened their work in some areas, but has made a definite contribution to the guidance of mothers especially with newborn infants. One area in which the PNP makes the greatest contributions is in the area of counseling. This is true even though physicians are oriented towards emotional support in health and disease and make an effort to spend extra time in assisting parents to cope. Many parents prefer to discuss their questions concerning toilet training, sleeping problems, and newborn care with the nurse practitioner. Pediatricians recognize that part of her skill is because she is a nurse whose education and experience has been oriented differently from that of a physician. The nurse practitioner is able to relate to parents in a unique way. She is not only a didactic teacher, and an interpreter of the physicians instructions, but she is also a counselor in her own right, an advisor, a listener, a helping professional.

The PNP also functions (psychologically) to prepare children who are being admitted to hospital. She has become involved in allergy testing and allergy counseling with families in whom this is a necessary part of the care of their children. The PNP has become involved in physical examinations of pre-adolescent girls since she is able to give special emphasis to sexual development and sex education counseling.

An Evaluation of Patient Reaction to the Nurse Practitioner

To determine patient reaction to the nurse practitioner, an informal survey was conducted by mailing a questionnaire to a group of old and new patients randomly selected. Even though the results are not statistically significant they give some indication of the reaction to the PNP. This survey was based on work done by Day, Egli and Silver[1].

Sixty-three per cent of old patients in the practice indicated that they felt the total pediatric services provided with the addition of the PNP had been improved; 71 per cent of new patients expressed a similar opinion. Ninety-two per cent of old patients felt that the PNP answered questions and managed problems in a completely satisfactory manner. Ninety-three percent of new patients felt likewise.

Of 11 old patients who had recently given birth to infants, 9 indicated that the care to newborns after hospital visits had been improved by the addition of the PNP. Eighteen of 19 new patients indicated that newborn care had thus been improved.

Ninety-seven per cent of old patients felt that telephone service had remained the same or improved with the PNP participating. All of 31 new patients felt the same way about these services.

Ninety per cent of old patients sampled were in favor of the continuing association of the pediatrician and the PNP. Ninety-seven per cent of 34 new patients sampled indicated that they too were in favor of this continuing association.

Thus, the majority of old and new patients felt that services of the pediatric nurse practitioner improved the total care in this practice. The PNP was seen as of value in assisting with questions and managing problems. She makes a contribution to the care of the newborn, and patients generally favored the continuing association with the pediatrician. These results are similar to those obtained in the initial study done by Day, Egli and Silver.[1]

Summary

Many of the tasks previously performed only by pediatricians in this practice have been delegated to a nurse practitioner. She has demonstrated her ability to perform these services not only as well as the physicians but in many areas better than they because of her skills, orientation, and her ability to take the necessary time.

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Rutgers Medical School

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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

P. O. Box 904, Trenton, New Jersey 08605

NEW JERSEY DOCTORS' NOTEBOOK

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President, CMDNJ

The College of Medicine and Dentistry of New Jersey has received a three year grant of $166,000 from the Hunterdon School Health Fund to undertake an evaluation of graduate medical education in New Jersey and to devise methods for assisting New Jersey hospitals in recruiting American-trained interns and residents.

The grant request to the Hunterdon Fund was an outgrowth of the activities of the Task Force on Graduate Medical Education—a group of health care providers and governmental agencies convened by the College to explore the problems of graduate medical education in New Jersey. With the receipt of the grant, the Task Force was enlarged and renamed the Advisory Council on Graduate Medical Education. It will provide guidance to the research staff funded by the Hunterdon grant.

Programs in graduate medical education (hospital-based training programs for interns and residents) have a critical impact upon the quality of medical care available and upon the retention of physician manpower within the State. Interns and residents provide an important source of 24-hour physician coverage for many hospitals. It is also recognized that a physician frequently settles and practices in the area where he received his graduate medical education. New Jersey has had great difficulty in attracting graduates of American medical schools to its internship and residency programs. Of the almost 1500 internship and residency positions offered in the State in 1972, only 273 were filled by graduates of American medical schools. It is essential that we look at the problem of graduate medical education on a State-wide basis and develop comprehensive solutions to problems that heretofore have been dealt with on a piecemeal basis.

The Research Director of the Graduate Medical Education Study and his staff, working under the guidance of the Advisory Council, will be addressing such problems as methods of recruiting graduates of American medical schools for internship and residency positions offered throughout the State, methods of funding internship and residency programs in community hospitals, and exploration of the means whereby the College of Medicine and Dentistry of New Jersey can act to strengthen programs in graduate medical education thus making them more attractive to graduates of American medical schools. The latter is particularly important in view of the current trend of the American Medical Association to place increasing weight upon medical school affiliations in their determinations of whether individual internship and residency programs shall receive approval.

An additional goal of the grant would be to develop a master plan for graduate medical education in New Jersey. Effort will be made to determine the number of specialists, such as surgeons, obstetricians, opthalmologists, and so on, in each area of the State and then to relate this need to the number of specialists actually practicing in each field. These data will constitute a vital tool in assisting the College and the Advisory Council to make recommendations concerning the need to increase or decrease the number of positions available in various specialty residency training programs.

The Advisory Council on Graduate Medical Education is composed of the following:

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New Jersey Association of Osteopathic Physicians and Surgeons

Dr. Edwin H. Albano, Director
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The New Jersey Regional Pharmaceutic and Therapeutic Drug Information Center, located at the Valley Hospital, Ridgewood, New Jersey, serves as a source of information on specific problems, articles, and reports concerning pharmaceutic and therapeutic information. A specialized library maintained by the Center contains complete information about U.S., foreign, investigational, and proprietary drugs, including their identification, availability, interactions, compatibility, side effects, dosage, adverse reactions, and so on.

The Center is staffed by trained pharmacists. Jack M. Rosenberg, Pharm. D., Associate Professor of Pharmacy and Director of Drug Information, Brooklyn College of Pharmacy, LIU, serves as Consultant Director. Salvatore Peritore, M.S., serves as Project Director, and Kenneth Anderson, Assistant Project Director. The service is provided free, open seven days a week, and is available by telephone—(201) 445-4900, extension 304. To date, over 2,000 questions have been received by the Center, the majority from physicians. Below are three questions and answers handled by the Center recently.

1. What information do you have regarding the treatment of breast cancer with calusterone?

Calusterone (Methosarb) is a synthetic steroid, chemically related to testosterone.

Gordon, *et al.*[1] reported on the effectiveness of calusterone in September 1970. At a dosage of 150 to 300 mg. orally per day, using the criteria of the Cooperative Breast Cancer Group, objective regression occurred in 14 of 22 women with advanced breast cancer.

In a later study Gordon[2] reported that calusterone produced objective regression in more than 50 per cent of those patients treated with metastatic breast cancer when used either as primary or secondary hormonal therapy.

A recently published controlled study[3] showed that calusterone produced objective regression in 28 per cent of the women treated for advanced breast cancer compared to an 18 per cent regression rate for testolactone (Teslac). Although the objective remission rate that was found differed from that reported by Gordon, *et al.*,[1, 2] the effectiveness of calusterone in the treatment of advanced breast cancer was clearly demonstrated.

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2. Gordon, G. S.: *JAMA,* 219:483 (January 24, 1972)

3. Goldenberg, I. S., *et al.: JAMA,* 223-1267 (March 12, 1973)

2. What relationship has been found between coffee drinking and myocardial infarction?

That coffee drinking may play some role in acute myocardial infarction (MI) was first suggested in December 1972 by the Boston Collaborative Drug Surveillance Program (BCDSP).[1] The data suggested that people who drank more than 5 cups of coffee per day had about twice as great a risk of having acute MI as persons who drank no coffee at all. They reported that the association between coffee ingestion and acute myocardial infarction was stronger than the association between cigarette smoking and MI.

To evaluate more clearly the association between coffee drinking and acute MI, a second survey of 12,759 hospitalized patients was undertaken by BCDSP.[2] This survey, based on a completely separate body of data, confirmed the association between coffee consumption and acute MI.

The relative risk of acute MI in those consuming either one to 5 or 6 or more cups of coffee per day was estimated to be increased by 60 per cent and 120 per cent respectively compared to those who drank no coffee.

The association could not be attributed to age, sex, past coronary heart disease, hypertension, congestive heart failure, obesity, diabetes, smoking, occupation, or the use of sugar with coffee.

The authors concluded that although a direct cause and effect relationship between coffee drinking and MI has not been established, even the possibility that coffee contributes to the risk of MI cannot be ignored.

References:

1. Boston Collaborative Drug Surveillance Program, *Lancet,* p. 1278 (December 16, 1972)

2. Jick, H., *et al.: N Engl J Med,* 289:63 (July 12, 1973)

3. Do you have any reports of mumps virus used to treat melanoma?

Our search revealed one study. Minton[1] recently published a report in which killed mumps vaccine was used in the treatment of metastatic melanoma. Eight patients were treated with surgical excision of the tumor, chemotherapy, BCG vaccine, and killed mumps virus vaccine. Five of the eight patients had additional clinical control of their melanoma when killed mumps virus was added to the immunologic stimulation sequence.

The sequence of the therapy appeared to play an important role in the development of tumor control.

Patients treated surgically, followed by immunologic stimulation, and then chemotherapy, responded poorly. Clinical performance was better in the patients treated with surgical excision, followed by chemotherapy, then immunologic stimulation with BCG vaccine, and finally killed mumps virus and BCG vaccine.

Reference:

1. Minton, J. P.: *Arch Surg,* 106:503 (April 1973)

Protective Custody for Children

Under the recently enacted Chapter 147 of New Jersey 1973 laws, physicians and hospital directors are authorized to take a child into protective custody if the child had suffered an injury at the hands of a parent or other person who normally would have charge of him. This is processed through the State Division of Youth and Family Services. The child may not be maintained more than three days under protective custody. Telephone the nearest district office of the Division of Youth and Family Services, as indicated in the following list. After hours, dial 800-452-9150 which is the toll-free state-wide emergency call for this service.

District Offices

County	Telephone No.
Atlantic	(609) 344-4141
Bergen	(201) 543-3400
Burlington	(609) 267-7550
Camden	(609) 964-4995
Cape May	(609) 344-4141
Cumberland	(609) 451-3100
Essex—except Newark	(201) 672-2900
Newark	(201) 648-2644
Gloucester	(609) 848-6604
Hudson	(201) 653-2750
Hunterdon	(201) 722-2224
Mercer	(609) 883-7970
Middlesex	(201) 249-4616
Monmouth	(201) 741-5220
Morris	(201) 539-3260
Ocean	(201) 244-4300
Passaic	(201) 742-1428
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Director

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Serum Parathyroid Hormone as a Diagnostic Aid

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The classic laboratory findings in primary hyper-rathyroidism are, of course, high serum calcium and v serum phosphorus; high urinary calcium is also mmonly found. Increased phosphate excretion due inhibition of phosphate reabsorption (TRP) and asurement of the TRP are additional laboratory s for diagnosing hyperparathyroidism. All of these ts are obviously indirect procedures for establish-the diagnosis so there is a distinct value in having irect measure of PTH.

In spite of the complexity and difficulty of the dioimmunoassay technic for PTH, it is now possible quantitate the hormone with reasonable precision d in most cases to differentiate normal from hyper-rathyroid serum levels. Human PTH is not available sufficient quantities to use as an antigen or stand-l, but guinea pig antiserum to bovine PTH has ficient cross-reactivity with human PTH to allow its ective use in the assay.

Unfortunately, the lack of a human parathyroid standard complicates any comparison of results from different laboratories. At Bio-Science a purified bovine PTH preparation is used as the standard and results are expressed as equivalents of purified bovine PTH. The antiserum used gives similar curves with both human serum PTH and purified bovine PTH and does not distinguish between the two.

The specimen requirement for the PTH assay is: 5 ml. frozen serum obtained from blood which has been drawn between 6 and 9 a.m. while the patient is in the rested, fasting state. The blood should be drawn with a chilled syringe or Vacutainer and kept in an ice bath until the serum can be separated, preferably in a refrigerated centrifuge. Separation of the serum from the cells and freezing should be completed as soon as possible. The frozen serum should be sent to us packed in dry-ice. Shipping containers intended for frozen specimen shipments are available without charge.

Write or call, collect, for additional literature on this subject and containers for mailing.

25 YEARS

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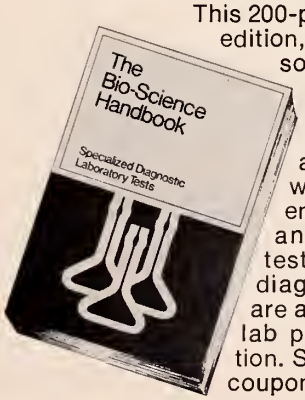
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PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

GASTROENTEROLOGY—Robert A. Pastore, M.D., 12262 East Arizona Drive, Aurora, Colorado 80012. Georgetown 1964. Board certified. Group or hospital. Available July 1974.

GENERAL PRACTICE—Suresh C. Doshi, M.D., 104-2A Oakville Drive, Pittsburgh, Pennsylvania 15220. University of Bombay 1961. Group, partnership, or house physician. Available.

INTERNAL MEDICINE—Charles H. Michalko, M.D., 616 Susan Drive, Ann Arbor, Michigan 48103. SUNY (Buffalo) 1966. Board eligible. Subspecialty, gastroenterology. Group or partnership. Available July 1974.

Ernest T. Bajpai, M.D., 111 East Mont Lane, Sicklerville 08081. Prince of Wales (India) 1955. Board eligible. Corporation, group, or partnership. Available July 1974.

Robert I. Birns, M.D., 2185 Lemoine Avenue, Fort Lee 07024. Washington University (St. Louis) 1970. Board eligible. Subspecialty, pulmonary medicine. Hospital, group, partnership, or solo. Available July 1974.

Kumar Ram Mohan, M.D., 264-08 Langston Avenue, Glen Oaks, New York 11004. Medical College, University of Madras (India) 1968. Board certified. Subspecialty, gastroenterology. Group, associate, or partnership. Available July 1974.

Austin M. Pattner, M.D., 5960 Culzean Drive, Dayton, Ohio 45426. SUNY (Syracuse) 1966. Board eligible. Subspecialty, nephrology. Group or partnership. Available September 1974.

OBSTETRICS-GYNECOLOGY—Che Yang Huang, M.D., 387 Carmen Road, Buffalo 14226. Taiwan University 1967. Board eligible. Group or partnership. Available.

Vasant V. Dalal, M.D., 10 Lamont Avenue, Apt. 11, Trenton 08619. King Edward Memorial Hospital (Bombay) 1962. Group, associate, or house physician. Available January 1974—as house or institutional physician now.

Bohdan Malyk, M.D., 1106 Winding Road, Dover, Delaware 19901. Jefferson 1968. Board eligible. Group or partnership. Available September 1974.

Dhan K. Chettri, M.D., 39 Wendover Road, Rochester, New York 14610. Calcutta Medical 1958. Board eligible. Group, partnership, or solo. Available.

ORTHOPEDICS—Edmund R. Kappy, M.D., 231 Palisade Road, Elizabeth 07208. New York Medical 1967. Board eligible. Group, associate, or partnership. Available.

PATHOLOGY—Pacifico C. Ramon, Jr., M.D., 142-02 84th Drive, Apt. 1-C, Jamaica, New York 11435. St. Tomas (Philippines) 1958. Board certified (A-P). Hospital, group, or partnership. Available.

Khwaja A. Siddiqui, M.D., 454 Garden Boulevard, Garden City, New York 11530. Kabul University (Afghanistan) 1962. Board eligible. Group, partnership, solo. Available.

PEDIATRICS—Stephen King, M.D., 3417 High Street, Dover, Delaware 19901. SUNY (Downstate) 1969. Group or partnership. Available September 1974.

Wen-Hsiung Lu, M.D., 3015 Tall Pine Lane #6, Jacksonville, Florida 32211. National Taiwan University 1963. Board eligible. Subspecialty, pediatric nephrology. Group or partnership. Available January 1974.

B. S. Paraswanath, M.D., 1005—18th Avenue, North, Nashville, Tennessee 37208. Mysore Medical College 1965 (India) Board certified. Subspecialty, neo-natology. Group or partnership, institutional or clinic. Available January 1974.

Hing-Ling Taang, M.D., One Bogardus Place, Apt. 2-N, New York 10040. Wuhan Medical College (China) 1960. Board eligible. Group, partnership, or pharmaceutical company. Available July 1974.

PSYCHIATRY—Charles D. Semel, M.D., 6303 Willowood Lane, Alexandria, Virginia 22310. Cornell 1968. Partnership, group, or solo. Available July 1974.

RADIOLOGY—Richard J. Rizzuti, M.D., 4774 West Braddock Road, Alexandria, Virginia 22311, SUNY (Downstate) 1968. Board certified. Group or partnership. Available July 1974.

SURGERY—Chong Wook Lee, M.D., 1945-20A Eastchester Road, Bronx, New York 10461. Yonsei Medical College, Seoul (Korea) 1963. Board eligible. Subspecialty, cardiothoracic surgery. Group, partnership, or solo. Available July 1974.

Arindam Purkayastha, M.D., Box 554, Johnson City, New York 13790. University of Calcutta (India) 1963. Board eligible. Group, partnership, or solo. Available.

UROLOGY—David J. Samara, M.D., 851 East Homestead Village, Rochester, Minnesota 55901. American University of Beirut 1969. Board Eligible. Group or partnership. Available July 1974.

PATRONIZE OUR ADVERTISERS

Newark Coordinated Family Planning Program

Twenty thousand Essex County women received health screening and family planning services in 1972 through the Greater Newark Coordinated Family Planning Project, a federally-funded program involving hospital family planning clinics, Planned Parenthood-Essex County, and the College of Medicine and Dentistry of New Jersey, New Jersey Medical School. More than twice as many patients were seen this year as in 1970, the first full year of the program," explained Dr. Harold A. Kaminetzky, project director and acting dean of the New Jersey Medical School. "We are gratified by the enthusiastic response of Essex County residents to the services here offered."

The over-all objective of the Greater Newark Coordinated Family Planning Project (GNCFPP) is to make freely available to all Essex County residents family planning advice, information, and services.

This includes contraceptive and infertility services; general medical screening for women, including V.D. tests, breast and cervical cancer detection, and medical referrals when indicated.

The concept of a coordinated system of family planning clinics in Essex County was the brainchild of Mary E. Singletary, executive director of Planned Parenthood-Essex County, who wrote the original proposal and was Dr. Kaminetzky's first appointment when he took over the chairmanship of the New Jersey Medical School obstetrics-gynecology department in 1968. The proposal was funded by the Department of Health, Education and Welfare in April, 1969, and services officially began in July of that year. There are now eight clinics in the program: four are in area hospitals (Martland, Orange Memorial, Newark Beth Isarel Medical Center, and United Hospitals Medical Center) and four are under Planned Parenthood-Essex County (two multi-lingual clinics and the main PP-EC clinic in Newark, and one in Montclair). In addition, PP-EC began providing services to employees of Prudential Insurance Company, Newark, in November 1972, holding a clinic weekly in the employee health center.

The GNCFPP grant is administered by a central staff at the New Jersey Medical School; Dr. Lee W. Davis, assistant professor of obstetrics and gynecology, is associate project director. Several staff members "wear two hats," as does Mrs. Singletary, who is assistant project director and also executive director of Planned Parenthood-Essex County. PP-EC has primary responsibility for the day-to-day administration, decision-making, training, supervision, and implementation of the project's goals and activities.

This year the Planned Parenthood-Essex County training department joined with the New Jersey State Department of Health family planning program and the Family Planning Program of New Jersey, Inc., to make available family planning services to all New Jersey residents. PP-EC trainers travel statewide, providing staff training for all HEW-founded family planning programs in New Jersey, and for others on request.

The Family Planning Nurse Specialist Program provides specialized training in family planning for registered nurses, and is sponsored by Planned Parenthood-Essex County, the New Jersey Medical School, and Planned Parenthood-World Population, Twenty nurses from eight states nationwide and the District of Columbia completed the course in 1972, and thirty are scheduled for 1973.

In a concentrated twelve-week program, the nurses receive instruction and practical experience in performing pelvic and breast examinations and the recognition of abnormalities; obtaining pap smears and gonorrhea cultures; technics of diaphragm fitting, IUD insertion, and selection of suitable oral contraceptives. They also study and have experience in family planning clinic organization and administration, as well as interviewing,

communications, and teaching skills. One of the first such formal training programs in America, the nurse specialist program will help alleviate the shortage of physicians and make family planning services more readily available, particularly in those rural and urban areas where medical personnel shortages are most acute.

Communicable Diseases in New Jersey

The following communicable diseases were reported to the Division of Laboratories and Epidemiology during July and August, 1973.

	1973 July	1972 July
Aseptic Meningitis	1	29
Hepatitis: Total	156	244
Infectious	101	165
Serum	46	79
Unspecified	9	0
Malaria: Total	2	1
Military	1	0
Civilian	1	1
Meningococcal meningitis	0	3
Mumps	61	19
German measles	44	6
Measles	51	8
Salmonella	83	85
Shigella	16	5

	1973 August	1972 August
Aseptic Meningitis	55	59
Primary Encephalitis	4	6
Hepatitis: Total	194	358
Infectious	84	289
Serum	41	69
Unspecified	69	0
Malaria: Total	0	2
Military	0	0
Civilian	0	2
Meningococcal meningitis	5	0
Mumps	26	8
German measles	8	3
Measles	25	0
Salmonella	113	94
Shigella	61	21

Immunization Action Month

The United States Public Health Service's Center for Disease Control, in cooperation with other medical, pharmaceutical, and health agencies, has agreed to sponsor October as Immunization Action Month. The nationwide program for immunization against measles, rubella, polio, whooping cough, and diphtheria will be directed to preschool age children.

National averages of the per cent of this population that has been vaccinated are sufficiently low to cause concern over the potential threat of epidemics. In New Jersey, the percentages of fully immunized children aged 1 to 4 years are significantly higher than nationally, except for rubella (German measles).

Nationally, the per cent of children fully vaccinated against polio is 63 per cent, the lowest level in nine years. DPT protection is at its lowest since 1966 with a 76 per cent average for the nation. The figure for children immunized against rubella (German measles) is 57 per cent and only 62 per cent of the 1 to 4 year old population has been immunized against measles.

The October program will encourage updating of immunity status of those currently in private or public health care systems. Immunization Action Month will motivate those who are not currently in a system to participate.

Pediatricians, family practitioners, and other physicians seeing young children in their offices are being asked to take a close look at the patients' records to determine susceptibility to the diseases in question. When deficiencies are found in individual immunizations, arrangements should be made to administer the vaccines.

It is anticipated that a large-scale public relations effort will take place in October to promote Immunization Action Month. We hope that physicians and local health officials will join in this campaign to improve the immunization status of children of New Jersey.

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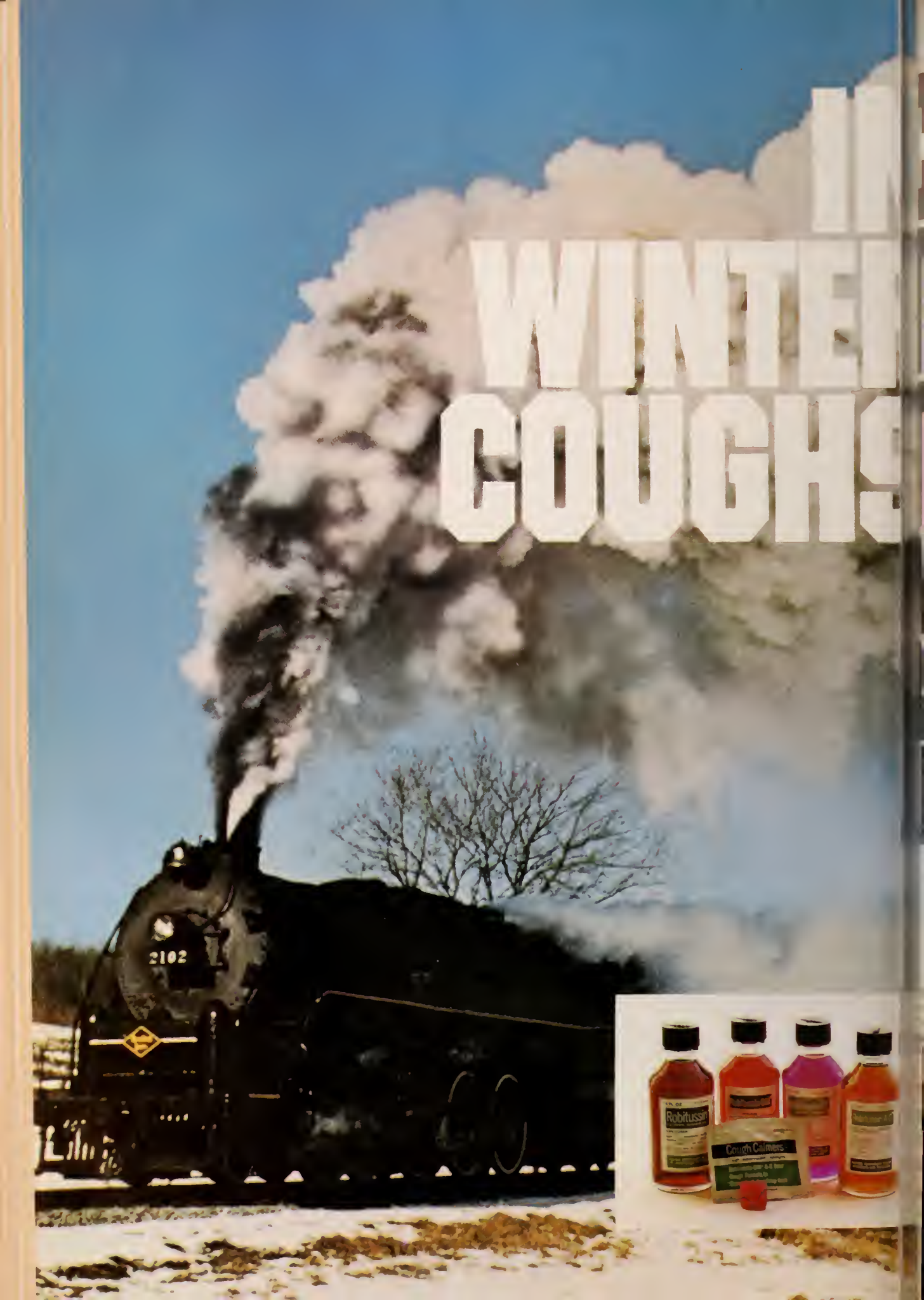
Kaolin	6.0 g.
Pectin	142.8 mg.
Hyoscyamine sulfate	0.1037 mg.
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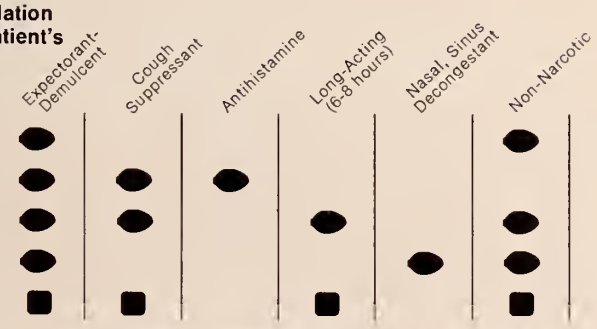
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LETTERS TO THE JOURNAL

A New FDA Regulation?

August 26, 1973

Dear Editor:

From items in the daily papers it seems that the FDA is about to remove from the market two very valuable drugs, Librium® and Valium.® It is high time that American doctors are awakened to the reality that their medical licenses soon will not be worth having. It appears that the FDA and other bureaucracies are intending to do our thinking, diagnosing, and prescribing. Are we to spend ten to thirteen years in study, take examinations for licensure, meet these costs, plus those of professional insurance and equipment, only to be clinical clerks? Some four years ago (or more) when the FDA prohibited the use of Parnate,® I published a protest in your *Journal*, entitled "Distilled Water and Sugar Pellets." Possibly the present head of the FDA hasn't seen my article. (Incidentally, Parnate® was restored to us, so perhaps I should write another "story.")

Twixt the inaction of the AMA and the overaction of the FDA, today's physicians certainly are in an awful mess. Possibly all physicians should go on strike and let the public find out how much HEW and the FDA can do without us. Nobody can object to having Librium® and Valium® procurable only upon written prescription, but anything more than that calls for action by both physicians and their patients.

(signed) Albert G. Hulett, M.D.

Inspection of Food Establishments

August 22, 1973

Gentlemen:

In May 1973, at the Annual Meeting of The Medical Society of New Jersey, I proposed Resolution #13 for "Better Protection of the Public from Eating Places Found Unsatisfactory" which called for publicizing persistent violators of the Sanitary Code in all news media. Strong opposition came from one source, namely Dr. Watson E. Neiman, deputy commissioner of health, who did succeed, finally, in weakening the original resolution. A substitute resolution was finally adopted by the House of Delegates. At that time newspaper accounts in the *New York Times* and *Star Ledger* stated that the Health Department officials opposed the publicity on the grounds that it would hurt businesses such as restaurants.

In the same newspapers of August 10, 1973, again Dr. Watson E. Neiman, with the support of Health Commissioner James R. Cowan, expressed opposition to inspection of kitchens in health care institutions. They declared that inspections of food kitchens in nursing homes, old age homes, and other health-care institutions would stop and that Chapter #12 of the State Sanitary Code will not apply. "A series of state food inspections that turned up violations at nursing homes and other health care facilities has been ordered halted by the State Health Department." The Consumer Health Section under Dr. Oscar Sussman had conducted 28 inspections which reported unsanitary conditions including poor food storage and rats. Dr. Neiman is quoted as saying "some of the doctors in the licensed health care facilities say it would have a bad psychological effect. The patient is locked in and if what they have to eat gets a conditional rating it might upset them mentally."

It appears that Dr. Neiman was deeply concerned that dirty unsanitary eating places that fail to correct violations might be closed and therefore he opposed Resolution #13. Now it seems that Dr. Neiman is very concerned that sick patients in health care institutions might be upset if they learned they were eating contaminated food in unsanitary kitchens. Apparently Dr. Neiman would not be upset nearly as much if a gastrointestinal or hepatitis outbreak occurred among patients in old

age and nursing homes as he would be if some patients were upset when they learned about unsanitary conditions in their institutions. I imagine that patients together with their visitors and relatives would be very happy to read a sanitary report that gave their institution a satisfactory rating. Think of the psychological effect of that knowledge!

When hearings were held in 1971 by the State Public Health Council prior to the adoption of the present Sanitary Code, organized medicine did not participate officially. I now challenge the Board of Trustees of The Medical Society of New Jersey to assume its responsibility and insist that all kitchens serving food be properly inspected as all kitchens in restaurants so that the sick and infirmed in our health-care institutions will be assured of getting proper food under sanitary conditions.

(Signed) Henry A. Brodkin, M.D.

September 10, 1973

Gentlemen:

I would like to reply to Dr. Brodkin's letter, concerning sanitary inspections of food establishments in the State of New Jersey in some detail.

With reference to Resolution #13, presented to the House of Delegates of The Medical Society of New Jersey in May of this year, the data used by Dr. Brodkin in preparing this Resolution was outdated and, therefore, inaccurate and misleading. The Reference Committee and the House of Delegates recognized the misleading character of the Resolution and adopted a changed Resolution which was more nearly correct. The New Jersey State Department of Health does not oppose any publicity concerning inspections of retail food establishments on the grounds that it would hurt businesses such as restaurants. On the contrary, every time a restaurant is found unsatisfactory, a press release is issued by this Department and the restaurant is posted as unsatisfactory and directed to cease operations in violation of Chapter 12 of the State Sanitary Code pertaining to inspection of retail food establishments. Some papers use the press releases; others do not. On the other hand, some newspapers in the State routinely visit the local health departments and publish weekly the results of all inspections whether the inspection is satisfactory, conditionally satisfactory, or unsatisfactory.

With reference to Dr. Brodkin's statement concerning inspection of kitchens in health care institutions, based upon an opinion rendered by the Office of the Attorney General, this office directed Dr. Oscar Sussman to cease conducting random inspections of health care institutions. However, Dr. Sussman was personally directed by me to make inspections of health care institutions when requested by this office; to set up, with the Assistant Commissioner for Health Facilities, a standard operating procedure to make unannounced inspections of the food preparation areas and eating facilities of all licensed health care facilities as a part of the licensing examination; and finally, Dr. Sussman was directed to make unannounced inspections of any health care facility upon receipt of a consumer complaint without reference to this office. Such inspections have been conducted and are continuing to be conducted; random inspections have been reinstituted.

The letter of Dr. Brodkin, as written, would lead one to believe that of the 28 inspections conducted by Dr. Sussman which reported unsanitary conditions including poor food storage and rats, would have resulted in unsatisfactory ratings for the institutions inspected. The facts are as follows: 28 health care facilities were inspected. One was found unsatisfactory. 13 were found conditionally satisfactory, which means that there were minor deficiencies, correctable in a short period time, and which posed no imminent hazard to public health. The remaining 14 institutions were found to be satisfactory.

Dr. Brodkin's quotation attributed to me which appeared in at least one newspaper in this state concerning the psychological effect on the patients in licensed health care facili-

ties is in essence correct, but was part of an interview conducted with me by a newspaper reporter, and does not necessarily reflect my own personal views. For example, in the official transcript of the minutes of the meeting of the Health Care Administration Board held in June 1973, a member of the Board said, "Right, why not post the bathroom if it's dirty, too. I mean, I think there is a point here that you can have a psychological or traumatic effect on a lot of people." My comments to the newspaper reporter were partially based on the minutes of the Health Care Administration Board and also do not necessarily reflect my own personal opinion. Incidentally, this discussion did not pertain to inspecting licensed health care facilities, but pertained only to posting of the results.

I regret very much the personal inferences made by Dr. Brodkin concerning my own feelings about inspection and posting of retail food establishments and health care institutions. I also regret that Dr. Brodkin did not see fit to contact me personally, either by letter or by telephone, before he wrote his letter to you. Had he done so, some of these points which he made in his letter could have been clarified, and perhaps he would not have found it necessary to write such a letter. At any rate, the pages of *The Journal* are no place for acrimonious dispute. I would be pleased to discuss my own personal viewpoints with Dr. Brodkin at any mutually convenient time. I am sure that Dr. Brodkin will find that he and I are both primarily concerned with the health and well-being of persons who eat in retail food establishments and persons who are patients in health care facilities.

(signed) Watson E. Neiman, M.D.

The family of our late Editor, Henry A. Davidson, M.D., has requested that, in lieu of other tributes, donations be made in his memory either to the Academy of Medicine of New Jersey or to the Essex County Mental Health Association. It is planned to initiate an annual symposium in Dr. Davidson's honor and donations should be made to the Educational Fund of the Academy of Medicine of New Jersey, 2424 Morris Avenue, Union, New Jersey 07083.

ANNOUNCEMENTS

Psychiatric Graduate Programs

Fair Oaks Hospital in Summit, in cooperation with the Academy of Medicine of New Jersey, has arranged the following programs in the series, "Current Topics in Psychiatry:"

October 10	Pathologic Conference Walter E. Uhlman, M.D.
October 24	Developments in the Depressions Peter Mueller, M.D.
November 7	Developments in Psychopharmacology Nathan S. Kline, M.D.
November 28	Thanatology Robert Cohen, M.D.
December 5	Hepatitis Willem Ten Hove, M.D.
December 19	Thyroid Diseases Theodore Dull, M.D.

Sessions are held from 3 to 4:30 p.m. (Wednesdays) at the hospital, 19 Prospect Street, Summit. Further information may be obtained from Granville L. Jones, M.D., Director of Research and Education.

Gastroenterology Series

A series of lectures on gastroenterology has been arranged jointly by Riverside, Saint Clare's, and Dover General Hospitals. All sessions are held from 9:30 to 11:30 a.m. at Riverside Hospital, Boonton. Subjects scheduled are as follows:

October 10	Peptic Ulcer
October 24	Pancreatitis
November 7	Malabsorption
November 28	Gastrointestinal Endoscopy
December 12	Hepatitis

To be announced later is a spring seminar of seven lectures on endocrinology and metabolic diseases (including gynecologic problems).

For detailed information, please write to the Joint Education Committee, Riverside Hospital, Boonton 07005, or telephone (201) 334-5000, extension 266.

Graduate Courses in Medicine

The following schedule, in the series, "Advances in Medicine," has been announced by the Bergen Pines County Hospital, Paramus. Sessions are held in the hospital auditorium from 9:30 to 11 a.m. on the Wednesdays indicated and collation is offered at 9 o'clock. For further information write to the Office of Medical Education, Bergen Pines County Hospital, Paramus 07652.

October 10	Diagnosis and Prognosis of AV Block Anthony N. Damato, M.D. U.S. Public Health Service Hospital, Staten Island, New York
October 24	Systemic Lupus Erythematosus Naomi F. Rothfield, M.D. University of Connecticut
October 31	Pathology of Breast Lesions Robert V. P. Hutter, M.D. Martland Hospital, Newark
November 7	Chemotherapy of Malignant Disease Franco M. Muggia, M.D. Einstein College of Medicine, New York
November 14	Psychopharmacology George Simpson, M.D. Bergen Pines Hospital, Paramus
November 21	Preinfarction Angina Harvey G. Kempt, Jr., M.D. St. Luke's Hospital, New York
November 28	Carcinoembryonic Antigen Phenomenon and Cancer Immunology Hans J. Hansen, Ph.D. Hoffmann-LaRoche, Nutley
December 5	Urticaria and Angioedema David J. McConnell, M.D. College of Physicians and Surgeons, New York
December 12	Cushing's Syndrome Norman H. Ertel, M.D. VA Hospital, East Orange
December 19	Clinical Pathology Conference Edward Wagman, M.D. Bergen Pines County Hospital, Paramus

Graduate Lectures in Surgery

The following programs have been announced for the 1973-1974 "Distinguished Lecture Series" offered by the Department of Surgery of the New Jersey Medical School, CMDNJ:

November 26	Small Bowel Resection and Gastric Hypersecretion John H. Landor, M.D., Professor Division of General Surgery Rutgers Medical School
December 10	Hiatus Hernia G. Robert Mason, M.D., Chairman Department of Surgery University of Maryland School of Medicine
January 28	Benign Lesions of the Breast William T. Fitts, Jr., M.D., Chairman Department of Surgery University of Pennsylvania School of Medicine
February 11	Metastatic Tumors of the Lung Paul C. Adkins, M.D., Chairman Department of Surgery George Washington University School of Medicine

Lectures are held at 4 p.m. in the amphitheater, 2nd floor, Martland Hospital, Newark. There is no charge. Guarded parking is available in parking lot M, 12th and Bergen Streets. For further information, please write to Eric J. Lazaro, M.D., Professor of Surgery, Martland Hospital Unit, CMDNJ, 65 Bergen Street, Newark 07107.

Pediatric Urology Seminar

At the Eden Roc Hotel in Miami Beach, a three-day colloquium is scheduled on pedia-

tric nephrology, for January 3, 4, and 5, 1974. Tuition is $125. A star-studded faculty has been obtained. For more details, write to the Department of Continuing Education, University of Miami Medical School, Box 875—Biscayne Annex, Miami, Florida 33152.

Ophthalmology Programs in Florida

The American Society of Contemporary Ophthalmology offers an AMA-accredited course in cataract, glaucoma, ophthalmic microsurgery, strabismus, plastic eye surgery, and other related topics from February 10 to 16, 1974, at the Fontainebleau in Miami Beach. For more details, write to American Society of Contemporary Ophthalmology at 30 North Michigan Avenue, Chicago 60602.

Plastic Surgery Course

From February 18 to February 20, 1974, Columbia University will offer a course in plastic and reconstructive surgery at St. Luke's Hospital, 113th Street at Amsterdam Avenue, in New York City. For more details write to Dr. Jose M. Ferrer, College of Physicians and Surgeons, 630 West 168th Street, New York City 10032 or telephone (212) 579-3682.

Proctology Seminar in Switzerland

The 26th Annual Seminar of the International Academy of Proctology will be held in Switzerland, May 3 to 17, 1974. Waldo W. Stiles, M.D. of Quito, Ecuador, President of the Academy, will preside.

Scientific sessions will be under the direction of Alvin D. Yasuna, M.D., of New York, Program Chairman. You are invited to attend the scientific sessions at which time practitioners from many parts of the world will present worthwhile scientific papers. For further information write to the Academy of Proctology, 147-41 Sanford Avenue, Flushing, New York 11355.

AMA CLINICAL CONVENTION

December 1 to 4, 1973 — Anaheim, California

The practicing physician's clinic for continuing education — **30 graduate courses in most specialties**
6 scientific sessions
Film symposia
Scientific exhibits
Conference on current status of PSRO's

Registration should be made with the Circulation and Records Department, AMA, 535 North Dearborn Street, Chicago, by November 5. Fee is $25 for a 4½-hour course; $40 for a 9-hour course. Medical students, interns, and residents may participate at half price. Refer to courses listed on AMA flyer distributed to membership earlier.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

October

10 **CMDNJ—Rutgers Medical School Academy of Family Practice, and Academy of Medicine of New Jersey**
University Heights, Piscataway
Cardiology Conference (every Wednesday through June 1974)

10 **Clara Maass Hospital and Academy of Medicine of New Jersey**
Clara Maass Hospital, Belleville
Continuing Education Courses
(every Wednesday through December 5)

10 **Bergen Pines County Hospital and Academy of Medicine of New Jersey**
Bergen Pines Hospital, Paramus
Advances in Medicine
(every Wednesday through January 1974)

Middlesex General Hospital, American Academy of Family Practice, and Academy of Medicine of New Jersey
Middlesex General Hospital, New Brunswick

10 *Multiple Sclerosis*

17 *Otologic Problems in General Practice*

24 *Neurologic Examination*

31 *Management of Thromboembolism*

10 **Academy of Medicine of New Jersey, New Jersey Lung Association, and Mountainside Hospital**
Mountainside Hospital, Montclair
Practical Pulmonary Problems

10 **Veterans Administration and CMDNJ**
Veterans Hospital, East Orange
Flow-Volume Loop Curves in Diagnosis of Pulmonary Disease

10 **Academy of Medicine of New Jersey**
Runnells Hospital, Berkeley Heights
Laboratory Interpretations

10 **Academy of Medicine of New Jersey**
Veterans Hospital, Lyons
Congestive Heart Failure

10 **Essex County Medical Society**
Carriage Trade, East Orange
Air Pollution

15 **Academy of Medicine of New Jersey**
Ancora Psychiatric Hospital, Hammonton
Depression

17 **Academy of Medicine of New Jersey**
Trenton Psychiatric Hospital, Trenton
Medical-Surgical Emergencies in Psychiatric Practice

18 **Academy of Medicine of New Jersey**
Helene Fuld Hospital, Trenton
Cardiac Arrhythmias

19 **Academy of Medicine of New Jersey**
Medical Center at Princeton
Fluid and Electrolyte Imbalance

19 **Academy of Medicine of New Jersey**
Mountainside Hospital, Montclair
Carcinoma of the Breast

24 **American Academy of Family Practice Veterans Hospital, East Orange**
St. Michael's Medical Center
Hematology Seminar

25 **Radiology Society of New Jersey and Academy of Medicine of New Jersey**
Hospital Center at Orange
Xeroradiography

November

Middlesex General Hospital, American Academy of Family Practice, and Academy of Medicine of New Jersey
Middlesex General Hospital, New Brunswick

7 *Pressure Neuritis*

14 *Unusual Infections*

21 *Medical and Surgical Emergencies in Psychiatry*

7-8 **Academy of Medicine of New Jersey American College of Surgeons, and American College of Emergency Physicians**
Cherry Hill Inn, Cherry Hill
Symposium for Emergency Department Personnel

7 **Academy of Medicine of New Jersey**
Bergen Pines Hospital, Paramus
Current Chemotherapy of Malignant Disease

7 **CMDNJ—New Jersey Medical School and Academy of Medicine of New Jersey**
New Jersey Medical School, Newark
Sexual Counselling

8 **Essex County Medical Society**
Carriage Trade, East Orange
PSRO

14 **Essex County Mental Health Association**
Veterans Hospital, East Orange
Loeser Lecture—Schizophrenias

14 **New Jersey Academy of Ophthalmology and Otolaryngology**
Robert Treat Hotel, Newark
Impaired Hearing, Neuro-ophthalmology, Cataracts

14 **Academy of Medicine of New Jersey**
John E. Runnells Hospital, Berkeley Heights
Electrolyte Imbalance

17 **Academy of Medicine of New Jersey**
Rutgers Medical School, Piscataway
Transitory Ischemia Attacks, Cerebral Vascular Insufficiency and Strokes

19 **Academy of Medicine of New Jersey**
Ancora Psychiatric Hospital, Hammonton
Drug Addiction

20 **Academy of Medicine of New Jersey**
Holy Name Hospital, Teaneck
Proper Use of Antibiotics

20 **Academy of Medicine of New Jersey**
Kessler Memorial Hospital, Hammonton
Fluid and Electrolyte Imbalance

21 **Academy of Medicine of New Jersey**
Trenton Psychiatric Hospital, Trenton
Acupuncture

21 **Veterans Administration and CMDNJ**
Veterans Hospital, East Orange
Big ACTH Possible Biologic Marker in Pulmonary Carcinoma

25 **Academy of Medicine of New Jersey and St. Joseph's Hospital**
St. Joseph's Hospital, Paterson
Cardiac Arrhythmias

27 **Academy of Medicine of New Jersey**
Warren Hospital, Phillipsburg
Management of Renal Failure

28 **Academy of Medicine of New Jersey**
Helene Fuld Hospital, Trenton
Management of Renal Failure

28 **Academy of Medicine of New Jersey and New Jersey Allergy Society**
Holiday Inn, Woodbridge
Pharmacologic Topics

December

4 **Academy of Medicine of New Jersey**
Holy Name Hospital, Teaneck
Difficult Diabetic Patient

Middlesex General Hospital, American Academy of Family Practice, and Academy of Medicine of New Jersey
Middlesex General Hospital, New Brunswick

5 *Stroke Prevention and Management*

12 *Acute Drug Intoxications*

19 *Determinants of Emotional Health*

5 **Academy of Medicine of New Jersey**
Fair Oaks Hospital, Summit
New Concepts in Hepatitis

6 **Radiology Society of New Jersey and Academy of Medicine of New Jersey**
Hospital Center at Orange
Cystourethrography in Children

8 **Academy of Medicine of New Jersey**
Morristown Memorial Hospital, Morristown
Surgery of the Hand

10 **CMDNJ—New Jersey Medical College**
Martland Hospital, Newark
Hiatus Hernia

11 **Academy of Medicine of New Jersey**
Paul Kimball Hospital, Lakewood
Thyroid Diseases

12 **Academy of Medicine of New Jersey**
Runnells Hospital, Berkeley Heights
Clinical Electrocardiography

18 **Academy of Medicine of New Jersey**
Holy Name Hospital, Teaneck
Proper Use of Blood Gases

19 **Academy of Medicine of New Jersey**
Trenton Psychiatric Hospital, Trenton
Fluid and Electrolyte Imbalance

19 **Academy of Medicine of New Jersey**
Fair Oaks Hospital, Summit
Thyroid Diseases

19 **Veterans Administration and CMDNJ**
Veterans Hospital, East Orange
Role of Respiratory Muscles in Respiratory Failure

January

Middlesex General Hospital, American Academy of Family Practice, and Academy of Medicine of New Jersey
Middlesex General Hospital, New Brunswick

2 *Dermatology and the Clinician*

9 *Hemoptysis*

16 *Office Evaluation and Management of the New Hypertensive Patient*

23 *Medical Complications of Acute Myocardial Infarction*

30 *Surgical Considerations in Management of Myocardial Infarction*

10 **Academy of Medicine of New Jersey**
Helene Fuld Hospital, Trenton
Diagnosis In Treatment of Shock

16 **Academy of Medicine of New Jersey**
Trenton Psychiatric Hospital, Trenton
Alcoholism

17 **Academy of Medicine of New Jersey**
Englewood Hospital, Englewood
Newer Concepts of Hepatitis

21 **Academy of Medicine of New Jersey**
Ancora Psychiatric Hospital, Hammonton
Medical-Surgical Emergencies in Psychiatric Practice

22 **Academy of Medicine of New Jersey**
Warren Hospital, Phillipsburg
Acupuncture

23 **Academy of Medicine of New Jersey**
Fair Oaks Hospital, Summit
Difficult Diabetics With Mental Illness

23 **Academy of Medicine of New Jersey and St. Joseph's Hospital**
St. Joseph's Hospital, Paterson
Clinical Symposia—Series II: Diabetes

24 **Radiological Society of New Jersey and Academy of Medicine of New Jersey**
Hospital Center at Orange
Venography of the Upper and Lower Extremities

30 **Academy of Medicine of New Jersey**
College of Medicine and Dentistry, Newark
Use of Blood Products for Transfusion

February

Middlesex General Hospital, American Academy of Family Practice, and Academy of Medicine of New Jersey
Middlesex General Hospital, New Brunswick

6 *Hormones, Hypertension, and Vascular Disease*

13 *Perspectives in Diabetes*

20 *Trends in Hyperalimentation*

27 *Biological Role of the Lymphocyte*

12 **Academy of Medicine of New Jersey**
Paul Kimball Hospital, Lakewood
Diagnosis and Treatment of Hypertension

18 **Academy of Medicine of New Jersey**
Ancora Psychiatric Hospital, Hammonton
Medical Legal Aspects of Medicine and Surgery

20 **Academy of Medicine of New Jersey and St. Joseph's Hospital**
St. Joseph's Hospital, Paterson
Clinical Symposia—Series VI: Neurology

20 **Academy of Medicine of New Jersey**
Helene Fuld Hospital, Trenton
Acupuncture

21 **Academy of Medicine of New Jersey**
Englewood Hospital, Englewood
Laboratory Interpretations

26 **Academy of Medicine of New Jersey**
Warren Hospital, Phillipsburg
Diagnosis in the Anemic Patient

28 **Radiological Society of New Jersey and Academy of Medicine of New Jersey**
Hospital Center at Orange
Tumors of the Small Bowel

March

Middlesex General Hospital, American Academy of Family Practice, and Academy of Medicine of New Jersey
Middlesex General Hospital, New Brunswick

6 *Paraneoplastic Syndromes*

13 *Neurological Complications of Systemic Cancer*

20 *Metabolic Bone Disease*

27 *Untoward Effects of Long-Term Steroid Therapy*

12 **Academy of Medicine of New Jersey**
Paul Kimball Hospital, Lakewood
Medical Legal Aspects of Medicine and Surgery

13 **Academy of Medicine of New Jersey**
Hunterdon Medical Center, Flemington
Infections Diseases

20 **Academy of Medicine of New Jersey**
Trenton Psychiatric Hospital, Trenton
Drug Addiction

21 **Academy of Medicine of New Jersey**
Englewood Hospital, Englewood
Proper Use of Antibiotics

24 **CMDNJ—New Jersey Medical School and Academy of Medicine of New Jersey**
Location to be announced
Problems in Obstetrics and Gynecology

26 **Academy of Medicine of New Jersey**
Warren Hospital, Phillipsburg
Diagnosis in Neurology and Neuro-Surgery

28 **Radiological Society of New Jersey and Academy of Medicine of New Jersey**
Hospital Center at Orange
Lumbar Spondylosis

April

Middlesex General Hospital, American Academy of Family Practice, and Academy of Medicine of New Jersey
Middlesex General Hospital, New Brunswick

3 *Eye Care in Family Practice*

10 *Gynecological Problems in Office Practice*

17 *Emergencies of Pregnancy and Labor*

24 *Pulmonary Function Testing*

4 **Academy of Medicine of New Jersey**
Helene Fuld Hospital, Trenton
New Developments in Scanning

10 **Academy of Medicine of New Jersey**
Runnells Hospital, Berkeley Heights
Acupuncture

15 **Academy of Medicine of New Jersey**
Ancora Psychiatric Hospital, Hammonton
Alcoholism

17 **Academy of Medicine of New Jersey and St. Joseph's Hospital**
St. Joseph's Hospital, Paterson
Clinical Symposia—Series VIII: Hypertension

18 **Academy of Medicine of New Jersey**
Englewood Hospital, Englewood
Bleeding Diseases

23 **Academy of Medicine of New Jersey**
Warren Hospital, Phillipsburg
Differential Diagnosis of Arthritis

25 Radiological Society of New Jersey and Academy of Medicine of New Jersey
Hospital Center at Orange
Total Body Scanning

May

Middlesex General Hospital, American Academy of Family Practice, and Academy of Medicine of New Jersey
Middlesex General Hospital, New Brunswick

1 *Environmental Cancer in the Year 2000*

8 *Unusual Causes of Heart Failure*

15 *Hemorrhagic and Septic Shock*

22 *Developments in Infectious Diseases*

29 *ENT in Office Practice*

11-14 The Medical Society of New Jersey
Haddon Hall, Atlantic City
Annual Meeting

22 Academy of Medicine of New Jersey
Trenton Psychiatric Hospital, Trenton
Suicide

23 Radiological Society of New Jersey and Academy of Medicine of New Jersey
Hospital Center at Orange
Arthrography

24 CMDNJ— New Jersey Medical School and Academy of Medicine of New Jersey
Location to be announced
Management of the Fetus at Rest

29 CMDNJ—New Jersey Medical School and Academy of Medicine of New Jersey
Location to be announced
The Problem Fetus

June

17 Academy of Medicine of New Jersey
Ancora Psychiatric Hospital, Hammonton
Diagnosis in Neurology and Neurosurgery

20 Academy of Medicine of New Jersey
Helene Fuld Hospital, Trenton
Diagnosis in the Anemic Patient

25 Academy of Medicine of New Jersey
Warren Hospital, Phillipsburg
Sarcoidosis

OBITUARIES

Dr. David F. Bentley, Jr.

One of Camden County's senior practitioners, David F. Bentley, Jr., M.D., died on August 16 at the age of 83. A urologist, board certified in his specialty, Dr. Bentley had been attending in that department at the Cooper Hospital, Camden, until his retirement. He was a graduate of Jefferson Medical College, class of 1914, and was a Fellow of the American College of Surgeons and a member of the American Urology Association. Recently he had been living in the Hightstown area.

Dr. Harry Cherashore

Born in 1890, Harry Cherashore, M.D., died at his home in Nutley on July 17, 1973. Dr. Cherashore was a 1913 alumnus of the old Medico-Chirurgical College of Philadelphia. He was one of the founders of the Passaic Beth Israel Hospital and was their attending pediatrician for many years. Dr. Cherashore was also affiliated with the Clara Maass Hospital in Belleville and St. Mary's Hospital in Passaic. He was active in committee work for our Essex County Medical Society prior to his retirement from practice five years ago.

Dr. Henry A. Davidson

On August 23, 1973, Henry A. Davidson, M.D., the renowned Editor of this *Journal* for thirty-two years, died suddenly at his home in East Orange, at the age of 68. (For editorial comment see page 725 of this issue.)

Dr. Davidson, a native of New Jersey, earned his bachelor's degree at Columbia University and received his doctorate in medicine from Jefferson Medical College in 1928. He devoted two years to the graduate study of neuropsychiatry, for which he received a master's in science degree from the University of Pennsylvania in 1931. After residencies in both psychiatry and neurology, he opened an office in Newark for the private practice of those specialities.

From 1942 to 1946 he served his country in the Army of the United States, mostly in the Pacific Southwest. Upon return to civilian life, Dr. Davidson accepted appointment as Chief of Psychiatry for the VA Regional Office in Newark and was soon promoted to Chief of Program Development in Psychiatry for the entire VA, an assignment which necessitated his moving to Washington, D.C. for a short time. In 1954, he became clinical director of the Essex County Overbrook Hospital in Cedar Grove, and three years later was named its Superintendent and Medical Director, a post he held until 1969, when he returned to private practice.

For many years, Dr. Davidson was a lecturer on hospital administration at Columbia University. During his early career he was on the faculty at Jefferson Medical College in the Department of Psychiatry, and more recently was Clinical Professor of Psychiatry at the College of Medicine and Dentistry of New Jersey.

Dr. Davidson entered the field of medical writing in 1931 as an abstract writer for the *Archives of Neurology and Psychiatry*. His appointment as Editor of this *Journal* came in 1941, following assignments in medical writing or editing with the *Year Book of Neurology, Psychiatry, and Endocrinology; Medical Economics;* and the *Bulletin of the Essex County Medical Society,* to name a few. He also authored six books.

Dr. Davidson was board certified in his chosen field and had held staff appointments at St. Barnabas Medical Center in Livingston and Newark Beth Israel Medical Center. For many years he was parliamentarian of the American Psychiatric Association. Recently, he was inaugurated as President of the Academy of Medicine of New Jersey, whose board of trustees he had served for many years.

Dr. John P. Dirr

Born in 1918, John P. Dirr, M.D., died on July 31, 1973. He was a family doctor with a special interest in industrial surgery. He was graduated from Hahnemann in 1944. Dr. Dirr was an assistant obstetrician at the Zurbrugg Hospital in Riverside, New Jersey. He was a Fellow of the (British) Royal Society of Health and participated in the work of the New Jersey Public Health Association. He was a member of our Burlington County Medical Society.

Dr. Harold Goldfield

One of Union County's best-known obstetricians, Harold Goldfield, M.D., died on August 5, 1973, at the age of 71. He was a 1926 Bellevue graduate and was senior attending in obstetrics at Elizabeth General Hospital. Dr. Goldfield was a Founding Fellow of the American College of Obstetricians and Gynecologists, and was active in the work of the New Jersey Obstetrical and Gynecological Society. In addition to his senior role at Elizabeth General Hospital, Dr. Goldfield was affiliated with both the Rahway Memorial Hospital and St. Elizabeth's Hospital in Elizabeth. He was a member of our Union County component society.

Dr. J. Reginald Harman

One of Mercer County's well-known obstetricians, James Reginald Harman, M.D., died on August 12, 1973. Born in 1905, Dr. Harman was a 1930 graduate of the Medical School of the University of Pennsylvania. He was chief of obstetrics at the St. Francis Hospital in Trenton, where he delivered over 10,000 babies during his 35 years of active practice. He retired in 1966 and last year moved to Mantoloking. He was a member of the New Jersey Obstetrical and Gynecological Society and a Fellow of the American College of Obstetricians and Gynecologists.

Dr. Charlie Henderson

At the untimely age of 50, Charlie Henderson, M.D., a family practitioner in Camden, died on August 13, 1973. Dr. Henderson received his M.D. degree from Meharry Medical College in 1963, and was an assistant in the department of internal medicine at the Cooper Hospital, Camden. He was a member of that county's component medical society.

Dr. Joseph E. Higi

One of the leaders in New Jersey dermatology, Joseph E. Higi, M.D., died on July 23, 1973 at the age of 72. Dr. Higi was a medical alumnus of St. Louis University, class of 1927. He was attending dermatologist at the Orange Hospital Center. He had been a football player at Notre Dame and always said that his football mentor, Knute Rockne, was the man who encouraged his entering medicine. For many years he maintained a lively interest in sports, and was, indeed, Tony Galento's personal physician.

Dr. Donald B. Hill

Donald B. Hill, M.D., a Montclair psychiatrist and member of our Essex County Society, died on July 27, 1973, at the untimely age of 57. He was an alumnus of New York Medical College, class of 1943, and served in the Army Medical Corps during World War II. Dr. Hill was a member of the American Psychiatric Association and the New Jersey Psychiatric Association, and was on the staff at the Montclair Community Hospital.

Dr. Alva Jenkins

Alva Jenkins, M.D., a well-known board-certified Bergen County internist, died on July 21, 1973. She had been born in 1909 and was only 64 at the time of her death. She was a 1935 alumna of the medical school at Howard University. Dr. Jenkins lived and practiced in Englewood. She was a Fellow of the American College of Physicians and an Associate in Administrative Medicine at Columbia University's School of Public Health.

Dr. Daniel E. Levendusky

Born in 1897, Daniel E. Levendusky, M.D., died on June 25, 1973 at the age of 76. He was a resident of Rockaway, New Jersey, an associate in internal medicine at Dover General Hospital, and active in committee work in our Morris County Component Society. He was a well-known family practitioner in his county. Dr. Levendusky was a 1924 graduate of the medical school at the University of South Carolina.

Dr. Edward Luczynski

A heart attack on July 19, 1973 took the life of Edward Luczynski, M.D., a 72-year old retired Hudson County obstetrician. Dr. Luczynski had been chief of obstetrics at the Bayonne Hospital and director of the Child Health Clinic of the Bayonne City Health Department. He had received his M.D. degree at Georgetown in 1928 and was active in our Hudson County Component Society. In 1963, Dr. Luczynski gave up active practice and moved to Lakewood where he was in retirement at the time of his death.

Dr. Sydney L. Neiderhoffer

A 1929 alumnus of McGill University Medical School, Sydney Neiderhoffer, M.D., died on July 15, 1973, at the age of 68. He had been a member of the Long Branch Board of Education and was active in civic and community affairs in that community. Dr. Neiderhoffer was a general practitioner with special interest in obstetrics. He was a member of the Monmouth County Medical Society and an attending physician at Monmouth Medical Center.

Dr. George Shugert

Word has recently come to us of the death on May 4, 1973 of George Shugert, M.D., of Ocean City. He had been born in 1915 and was only 58 years old at the time of his death. He was a general practitioner affiliated with the Shore Memorial Hospital at Somers Point. Dr. Shugert came to us from Philadelphia where he had practiced from 1941 to 1971 when he came to our State. He was a member of our Cape May County Medical Society.

Dr. Moses C. Sucoff

Born in 1894, Moses C. Sucoff M.D., one of Passaic's well-known surgeons, died on August 16, 1973. He received his medical degree from Columbia University's College of Physicians and Surgeons in 1921, and was formerly a member of the surgical staffs of Barnet Memorial Hospital in Paterson and the Passaic Beth Israel Hospital. He was a Fellow of the American College of Surgeons and a member of the prestigious Society of Surgeons of New Jersey.

BOOK REVIEWS

Current Concepts of Amphetamine Abuse. Edited by Everett Elinwood, M.D. and Sidney Cohen, M.D. Rockville, Maryland, National Institute of Mental Health, 1972. DHEW Publication 72-9085, Pp. 238. (Softback—$3.50)

Some 23 million prescriptions are written annually for amphetamines. Middle-aged victims of amphetamine addiction were generally introduced to the drug by physicians who had prescribed it for weight loss, narcolepsy, relief of fatigue, or control of depression. Younger people generally obtain amphetamines through illegal channels. In June 1970, the National Institute of Mental Health sponsored a colloquium on amphetamine abuse and the transactions of that seminar are here reproduced.

The papers themselves and the free discussions which followed are found in this paperback. There is much material on the physiologic chemistry of amphetamines. There is no concealing of the fact that abuse may provoke withdrawal symptoms, paranoid disorders, and liver and brain cell damage. Amphetamines seems to produce a feeling that the taker will be better able to master his environment. This is in contrast to opium alkaloids, where the purpose is to get away from the tensions of life rather than to master them.

The book touches on many aspects of physiological and clinical research in the pharmacology of amphetamines, but has very little to offer the clinician in terms of treatment of the addict or control of the abuse.

Leo J. Barone, M.D.

Your Prostate. Robert L. Rowan, M.D. and Paul Gillette, Ph.D. Garden City, New York, Doubleday, 1973. Pp. 147. Illustrated. ($5.95)

In this short book, Dr. Rowan and Dr. Gillette have included a great deal of information for the layman with prostate trouble. The subject has been sensibly divided and clearly presented, with discussions of prostatitis, benign prostatic hypertrophy, and carcinoma of the prostate.

The material is presented in a somewhat dogmatic manner so that the patient might be tempted to challenge his doctor in regard to his diagnosis and treatment. For instance, the authors say that with an elevated acid phosphatase "prostatic cancer has begun to spread." Allowance has to be made for the rather frequent false positive elevations of acid phosphatase. As the authors have *not* done so, the reader inquiring of this test result may wrongly conclude that he has widespread terminal disease, or that his physician is not telling the truth to him.

The book includes several outright misstatements. In discussing open perineal prostatic biopsy they say "speed is of the essence. If there is any doubt as to the presence of cancer cells, the surgeon will take the safer course and remove the suspect organ or organs." Most urologists do not perform a radical prostatectomy with an equivocal frozen section. Malpractice suit, anybody? On the next page, "if a portion of the gland is removed, prostatectomy is said to be radical." I would have thought that Dr. Rowan would not allow such a gross error.

As a book for the layman, it does give insight into the most common prostatic conditions. Since it is so clearly written and generally accurate, except for the above flaws, you may recommend it to your inquisitive patients. But, warn them that the authors have omitted that important ingredient known as clinical judgment.

Robert H. Stackpole, M.D.

Medicine in a Changing Society. Edited by Lawrence Corey, M.D., Steven Saltman, M.D., and Michael Epstein, M.D. St. Louis. Mosby, 1972. Pp. 228. Softback ($6.50)

At the University of Michigan in 1968, medical students began to press for changes in subject matter, teaching technics, and schedules. They wanted active participation in school policy-making. They felt that they could not practice medicine honestly or effectively without understanding the social, moral, and ethical aspects of practice. They resented the implication that the medical student was a "hollow container to be filled with facts." This new approach brought vigor and innovation to Michigan's medical training program.

Much material has been assembled here. The 17 contributors include seven M.D.'s, plus sociologists, hospital administrators, labor leaders, public health officials, health administrators, and Senator Kennedy. In its content, the text tells us about "the pathology of poverty," consumer expectations of health services, the role of health insurance and community health centers, and the strengths and limitations of Medicaid and Medicare. The material is readable and generally thought-provoking. The book is basic reading for any physician who wants an in-depth review of these new but important topics. The volume will sweep the cobwebs out of our intellectual furniture.

Henry A. Davidson, M.D.

Review of Medical Physiology, Sixth Edition. W. F. Ganong, M.D. Los Altos, California, Lange, 1973. Pp. 572. Illustrated. (Softback $9)

The practitioner too rapidly grows away from the human physiology he learned in his medical school days. And relatively little in clinical practice keeps refreshing his memory. So it is good that from time to time a physiology text is made available. This is the sixth edition (in ten years) of Ganong's well-known book. Although the author modestly describes it as "a concise summary," it actually presents the mechanism of the functioning of the human organism in real depth. The text covers the usual subheadings expected in a physiology book: the functioning of vision, hearing, maintenance of posture, transmissions of impulses through nerves and muscles, metabolism, circulation, endocrine activities, respiration, and urinary secretion. Some 40 tabulations, dozens of line drawings, conversion tables, and listing of normal values all add richness to the volume. There has been much interest in the last few years in biochemical explanations for metabolic changes (including emotional changes) that the extensive display of an explanation of structural formulae seem appropriate.

This book has been translated into five foreign languages and this alone is a well-merited accolade to its usefulness.

Abraham Leff, M.D.

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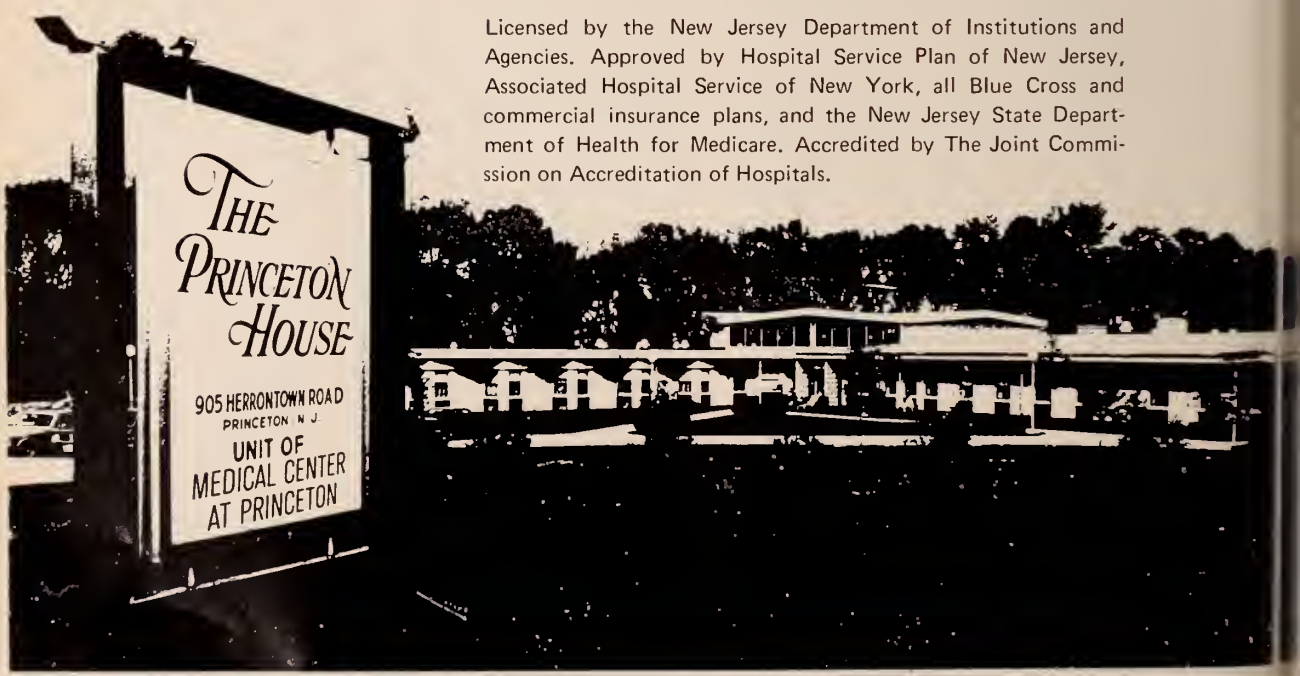
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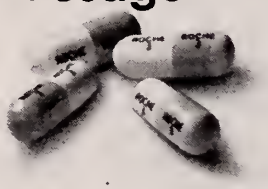
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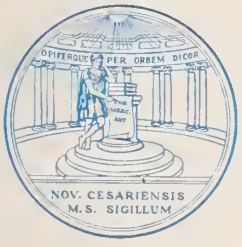
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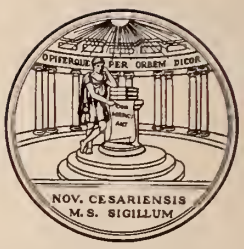
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ication, consider Dalmane—a single entity nonnarcotic, non-
iturate agent proved effective and relatively safe for relief of
mnia.

DALMANE®
(flurazepam HCl)

When restful sleep is indicated

One 30-mg capsule *h.s.*—usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*—initial dosage for elderly or debilitated patients.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening. In patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE

ROCHE LABORATORIES
Div., Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

The Weight of Professional Opinion

It's time for action to defend the laws and regulations that protect your patients against drug substitution.

These professional and trade organizations are united in supporting antisubstitution statutes and regulation

The American Academy of Dermatol

The Board of Directors of the American Academy of Family Physicians

The Executive Board of the American Academy of Neurology

The Committee on Drugs of the American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the American College of Obstetricians and Gynecologists

The Board of Regents of the American College of Physicians

The Board of Trustees of the American Dental Association

The Board of Trustees of the American Medical Association

The American Psychiatric Associat

The Executive Committee of the National Association of Retail Druggists

The Board of Directors of the Pharmaceutical Manufacturers Association

The National Wholesale Druggists' Association



›int Statement on Antisubstitution Laws and Regulations

The purpose of this statement is affirm the support of the participat- g organizations for the laws, regula- ›ns and professional traditions which ohibit the unauthorized substitution drug products.

Traditionally, physicians, den- ›ts and pharmacists have worked ›operatively to serve the best inter- ›ts of patients. Productive coopera- ›n has been achieved through utual respect as well as a common ›ncern for the ideals of public rvice. This mutual respect has been flected, in part, by joint support er the years for the adoption and ›forcement of laws and regulations ›ecifically prohibiting unauthorized ›bstitution and encouraging joint scussion and selection of the urce of supply of drug products. ›e basic principles of medical, den- l and pharmacy practice are thus ilized and preserved in the interest patient welfare.

The antisubstitution laws have ›t obstructed enhancement of the ofessional status of pharmacy any ore than they have in and of them- lves guaranteed absolute protec- ›n from unsafe drugs, or freed ›ysicians, dentists and pharmacists ›m their responsibilities to patients. a practical matter, however, such ›ws and regulations encourage inter- ofessional communications regard- g drug product selection and assure ch profession the opportunity to ercise fully its expertise in drug age, to the advantage of patients.

Physicians and dentists should urged to increase the frequency d regularity of their contacts with armacists in selection of quality ›g products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D. C. 20005

ROCHE announces new BACTRIM™

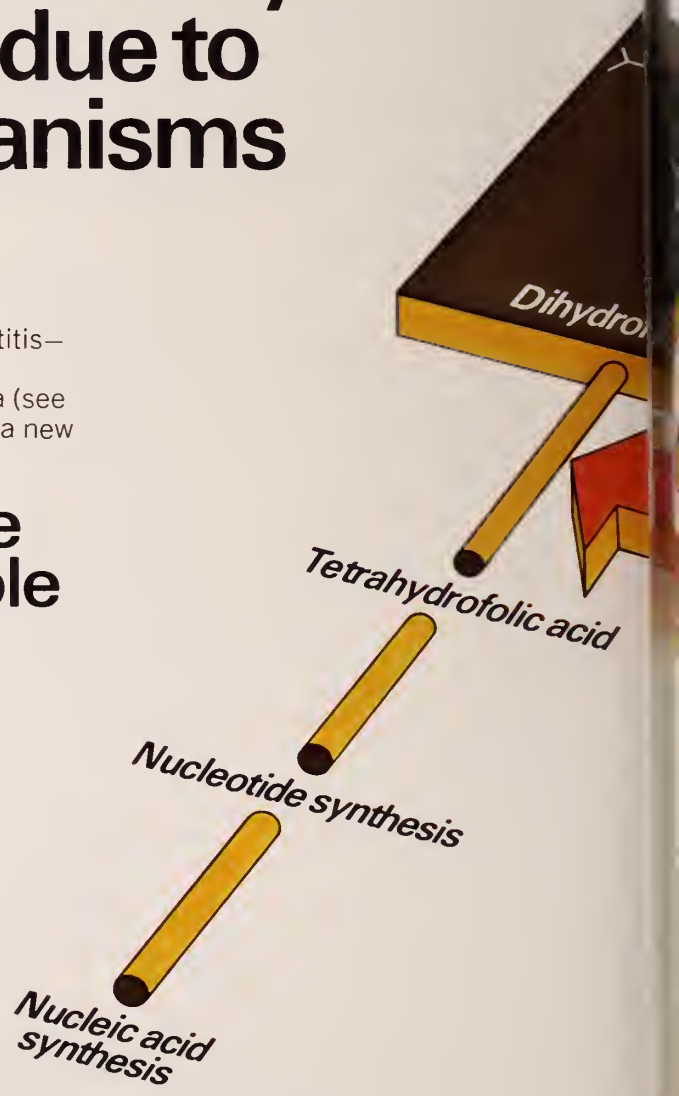
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

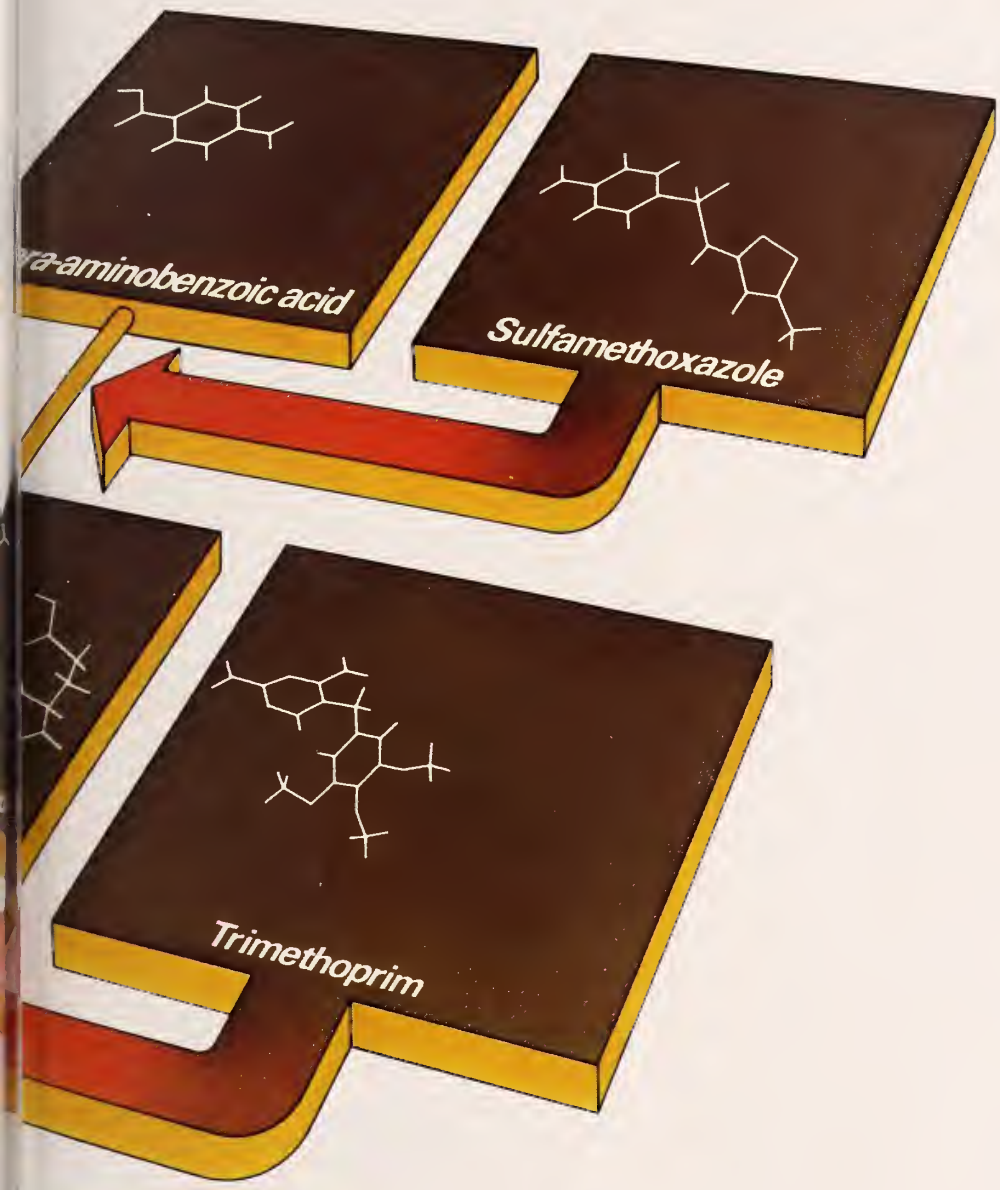
a new type of antibacterial for a two-pronged attack against chronic urinary tract infections due to susceptible organisms

Bactrim is highly effective in the treatment of these infections—primarily pyelonephritis, pyelitis and cystitis—when due to susceptible organisms. This efficacy is related to the unique mode of action against bacteria (see illustration), an action that, in effect, makes Bactrim a new type of antibacterial.

Bactrim interrupts the life cycle of susceptible bacteria

Unique mode of action interrupts the life cycle at two important points, thereby impeding the production of nucleic acids and proteins essential to these bacteria. These consecutive interruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing substrates. By competitive replacement of these substrates, they inhibit further synthesis.





ROCHE

new **BACTRIM**™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

Before prescribing, please see complete product information on last page of advertisement.

Excellent clinical response in chronic urinary tract infections even with obstructive complications

A multiclinic, double-blind study* of response to a ten-day course of therapy in 471† patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant bacteriological response to Bactrim, compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. More than half of these patients had obstructive complications.

Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after a ten-day course of therapy with Bactrim, 68.4% of patients with chronic urinary tract infections *maintained* response for up to 42 consecutive days, compared with 59.7% with trimethoprim and 44.4% with sulfamethoxazole. These results are particularly noteworthy considering the number of patients with obstructive complications—cases regarded as being notoriously difficult to treat.

Prescribing considerations

Clinical Limitations: Currently, the increasing frequency of resistant organisms is a limitation of th usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections. Not recommended for children under twelve.

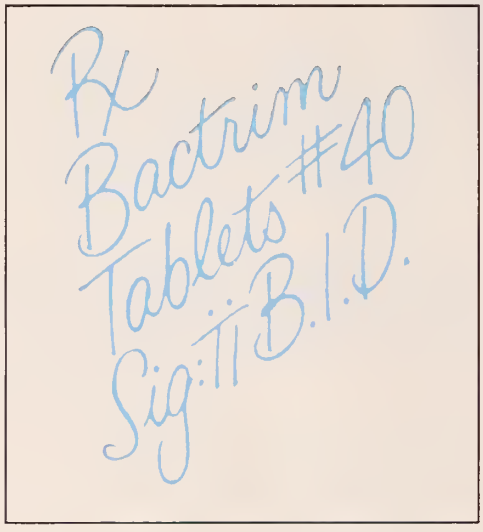
Contraindications: Hypersensitivity to trimethopri or sulfonamides. Pregnancy and during the nursing period.

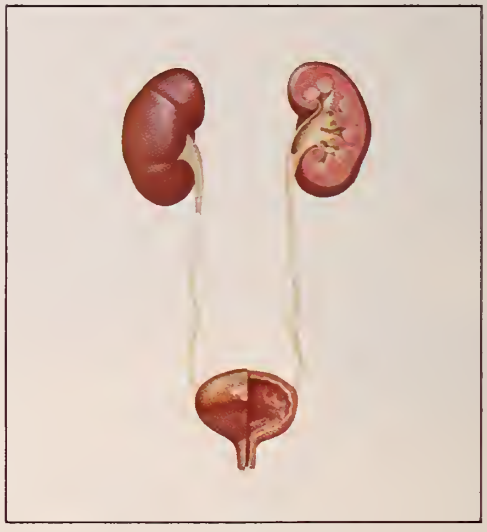
Warnings and Precautions: Both sulfamethoxazol and trimethoprim have been reported to interfere with hematopoiesis. Complete blood counts shoul be done frequently. If a significant reduction in th count of any formed blood element is noted, Bactri should be discontinued. Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. Maintain adequate fluid intake. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Effects: Among the most common side effects are nausea, vomiting, rash, leukopenia and elevations in SGOT and creatinine.

Usual adult dosage: two tablets every twelve hour for 10 to 14 days; no loading dose required.

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110
†4 patients not available for evaluation at day 10.





new **BACTRIM**™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, N.J. 07110

Before prescribing, please consult complete product information on facing page.

omplete Product Information:

escription: Bactrim is a synthetic antibacterial combination prodct, available in scored light-green tablets, each containing 80 mg imethoprim and 400 mg sulfamethoxazole.

rimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. is a white to light-yellow, odorless, bitter compound with a molecar weight of 290.3.

ulfamethoxazole is N^1-(5-methyl-3-isoxazolyl)sulfanilamide. It is almost white in color, odorless, tasteless compound with a mocular weight of 253.28.

:tions: *Microbiology:* Sulfamethoxazole inhibits bacterial synthesis dihydrofolic acid by competing with *para*-aminobenzoic acid. imethoprim blocks the production of tetrahydrofolic acid from dirofolic acid by binding to and reversibly inhibiting the required nzyme, dihydrofolate reductase. Thus, Bactrim blocks two conutive steps in the biosynthesis of nucleic acids and proteins sential to many bacteria.

vitro studies have shown that bacterial resistance develops more owly with Bactrim than with trimethoprim or sulfamethoxazole one.

vitro serial dilution tests have shown that the spectrum of antiacterial activity of Bactrim includes the common urinary tract thogens with the exception of *Pseudomonas aeruginosa.* The folwing organisms are usually susceptible: *Escherichia coli, Klebella-Enterobacter, Proteus mirabilis* and indole-positive proteus ecies.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms
(MIC—mcg/ml)

acteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20) TMP	SMX
scherichia oli	0.05—1.5	1.0 —245	0.05—0.5	0.95— 9.5
roteus spp. ndole positive	0.5 —5.0	7.35 —300	0.05—1.5	0.95—28.5
roteus irabilis	0.5 —1.5	7.35 — 30	0.05—0.15	0.95— 2.85
lebsiella-nterobacter	0.15—5.0	0.735—245	0.05—1.5	0.95—28.5

man Pharmacology: Bactrim is rapidly absorbed following oral ministration. The blood levels of trimethoprim and sulfamethoxae are similar to those achieved when each component is given ne. Peak blood levels for the individual components occur one four hours after oral administration. The half-lives of sulfamethzole and trimethoprim, 10 and 16 hours respectively, are rela:ly the same regardless of whether these compounds are admin:red as individual components or as Bactrim. Detectable ounts of trimethoprim and sulfamethoxazole are present in the od 24 hours after drug administration. Free sulfamethoxazole d trimethoprim blood levels are proportionately dose-dependent. repeated administration, the steady-state ratio of trimethoprim ulfamethoxazole levels in the blood is about 1:20.

famethoxazole exists in the blood as free, conjugated and pron-bound forms; trimethoprim is present as free, protein-bound d metabolized forms. The free forms are considered to be the rapeutically active forms. Approximately 44 percent of trimethim and 70 percent of sulfamethoxazole are protein-bound in the od. The presence of 10 mg percent sulfamethoxazole in plasma creases the protein binding of trimethoprim to an insignificant ree; trimethoprim does not influence the protein binding of famethoxazole.

retion of Bactrim is chiefly by the kidneys through both glomerr filtration and tubular secretion. Urine concentrations of both famethoxazole and trimethoprim are considerably higher than the concentrations in the blood. When administered together in Bactrim, neither sulfamethoxazole nor trimethoprim affects urinary excretion pattern of the other.

ications: Chronic urinary tract infections (primarily pyelonephrit pyelitis and cystitis) due to susceptible organisms (usually *coli, Klebsiella-Enterobacter, Proteus mirabilis,* and, less frentl, indole-positive proteus species).

ortant note: Currently, the increasing frequency of resistant organs is a limitation of the usefulness of all antibacterial agents, espey in the treatment of chronic and recurrent urinary tract infections.

traindications: Hypersensitivity to trimethoprim or sulfonamides. gnancy and during the nursing period (see Reproduction dies).

nings: Deaths associated with the administration of sulfonamides e been reported from hypersensitivity reactions, agranulocyto aplastic anemia and other blood dyscrasias. Experience with ethoprim alone is much more limited, but it has been reported nterfere with hematopoiesis in occasional patients. In elderly ents concurrently receiving certain diuretics, primarily thias, an increased incidence of thrombopenia with purpura has n reported.

The presence of clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued.

At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

Precautions: Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Reactions: For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia.

Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

Miscellaneous reactions: Drug fever, chills, and toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L. E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration: Not recommended for use in children under 12 years of age.

The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

How Supplied: Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Paks of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

Reproduction Studies: In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

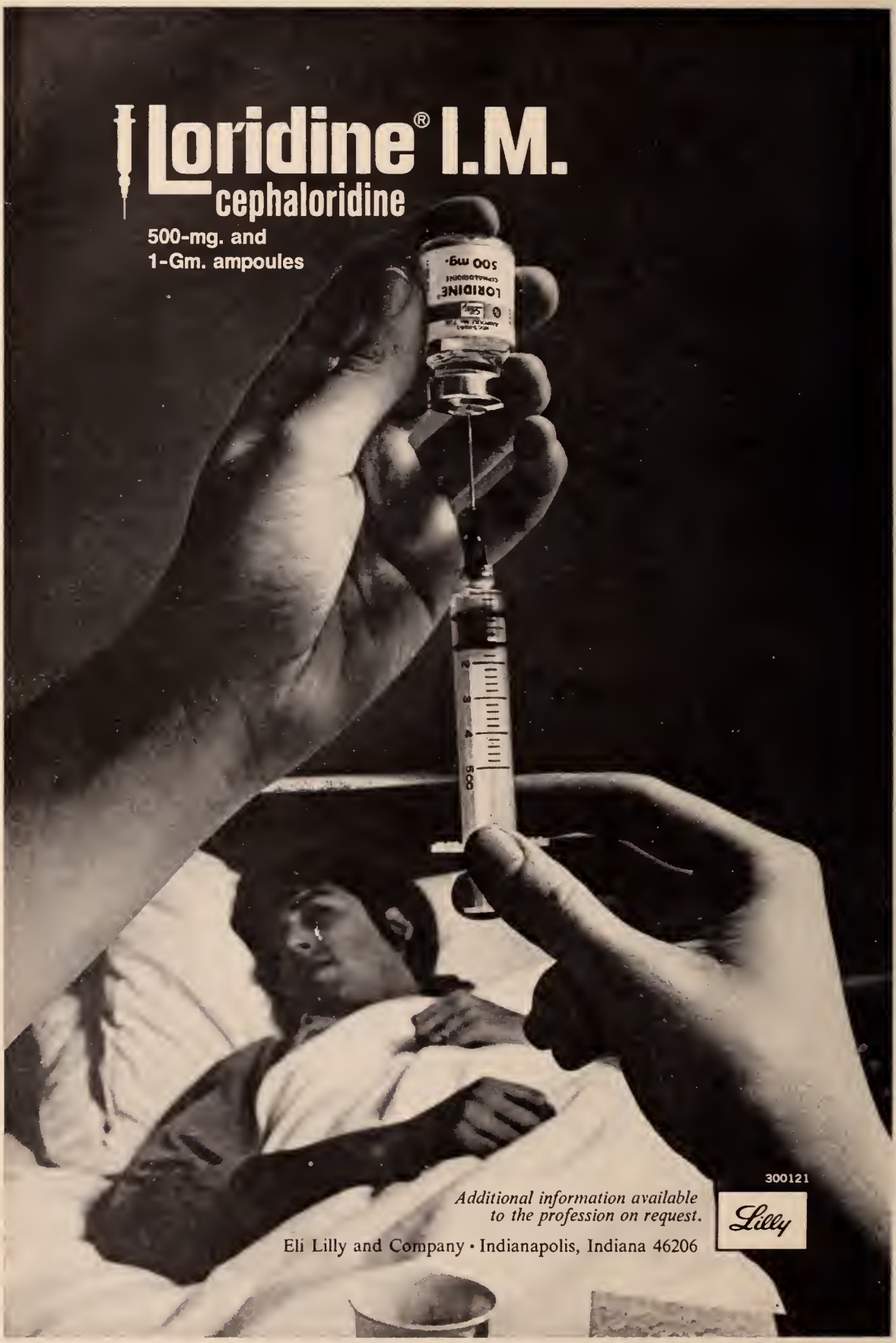
In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

BACTRIM™

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

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EDITORIALS

Two Decades of Diabetes Screening in New Jersey

Along with the New Jersey Diabetes Association and the New Jersey State Department of Health, The Medical Society of New Jersey will celebrate its 20th anniversary of organized diabetes case-finding this year. This triumverate of organizations, in the interest of public health and public service, has sponsored, arranged, and implemented a state-wide effort in disease detection annually since November 1954. Each of the component county medical societies, through a committee on diabetes detection and education, has spearheaded the grassroots effort, with the voluntary cooperation of woman's auxiliary members, representatives of county and local health departments, hospital personnel, workers from services clubs, and others.

What has been accomplished by such an effort? Incomplete statistical reports disclose that over half a million individuals were screened and more than 18,000 diabetes "suspects" were uncovered. Definitive follow-up evaluation by personal physicians or physicians in a clinic or health center confirmed newly diagnosed diabetes in over 3,000 of these citizens.

The history of diabetes detection in our state has shown a technological evolution from urine testing to blood glucose evaluation, utilizing inexpensive, reproducible electronic devices which require only a drop of blood. The great interest of the non-professional public in health has resulted in a degree of sophistication which has increased the participation in mass screening, as well as the individual desire for health maintenance examinations and health supervision.

The purpose of diabetes detection is to assist the physician to discover latent (or symptomatic but undiagnosed) disease so as to direct his patient toward a more optimum health status by the use of nutrition and other health instruction, by general hygienic measures, and by a specific diabetes therapy program. This may include medication, exercise, and the like. This type of community health program—detection followed by evaluation, education, and treatment—illustrates how diabetes mellitus is a nice clinical model for the demonstration of preventive medicine in action.

The fruits of 50 years of research in diabetes, since the discovery of insulin, are beginning to make themselves known, while newer knowledge in immunology, transplant surgery, laser therapy, and epidemiology have proved most exciting.

Why detect diabetes? There are a myriad of reasons to do so, if only to prevent acute complications. The real reason is clear, however. Each diabetic should have the benefit of the best health possible for the longest period of time, so that he will be able to take advantage of a major research breakthrough when it comes. In this regard, each physician in New Jersey is urged to be aware of National Diabetes Week: November 11-17, 1973. Assist your county medical society committee chairman in whatever way you can. Urge your high risk patients to be tested. Remember that diabetes detection gains impetus the week before Thanksgiving, but it should be a year-round activity.

A.K.

Increased "Life Plan" Limits

The Medical Society of New Jersey Life Plan now provides up to $250,000 of coverage for members. In addition to the original Nationwide Life Insurance Plan which provides $150,000 of coverage, we added $100,000 under the Bankers Life Company Supplemental Plan. The dual program has the important extra advantage that many of our members

have increased amounts of insurance available without the necessity of physical examinations.

November is Life Month for the original Nationwide Life Insurance Program. Members can apply for additional units under this program. Each unit of insurance provides $10,000 of death protection with double indemnity in case of accidental death. Every unit has a guaranteed conversion provision as well as a waiver of premium provision without extra charge.

A special Life Month mailing is being sent this month by our Administrator, E. & W. Blanksteen Agency, Inc. Look for your application in the mail. The Administrator will be happy to provide help and information as to the best uses of the total program for your circumstances.

D.B.

Will Unrealistic Standards Force Some Hospitals into Bankruptcy?

"Some hospitals will go bankrupt," if there is no relief from "arbitrary and unrealistic controls" and government "harassment," said John W. Kauffman, chairman of the board of the American Hospital Association.

Mr. Kauffman and the association's new president, John Alexander McMahon, responded vigorously to recent Administration moves, which they described as "one blow after another" and "an implied threat to the health of the American people." Mr. McMahon promised a "forceful action program" to attack "intolerable problems" and express the AHA's "frank disagreement" with the Administration.

In predicting the possible bankruptcy and closure of some hospitals as a result of the combined effect of the government's actions, Mr. Kauffman stressed two problems: the continuation of hospital price controls under Phase III and the elimination of advance payments from the government for Medicare services.

Phase III economic controls, which single out health and a few other industries, hospital officials warn, might precipitate severe cutbacks in services. "We find that we are one of three industries in this nation that will continue under stricter control in Phase III, and the rest of the economy is on a voluntary basis," Mr. Kauffman said. "We are concerned about our selection for the special treatment."

Foreseeing a widening gap between what hospital suppliers may demand and what the hospitals will be able to afford under the restrictions, Mr. McMahon said that he feared an erosion of the ability of hospitals to serve patients, with the closure of floors and elimination of some services, if not the bankruptcies foreseen by Mr. Kauffman.

A list of "typical" price increase examples distributed by the AHA noted increases of 3.8 per cent for sutures in Indiana to 68.8 per cent for medical gases and anesthetics in Tennessee. While association officials did not identify the specific hospitals or suppliers, their examples indicated an average increase of about 15 per cent for such items as poly bags, liability insurance, and telephone costs.

Another of the major problems foreseen by the AHA officials was the elimination of the current financing portion of the Medicare program under which hospitals received advance payments to cover delays of up to four weeks, according to Mr. Kauffman (only two weeks, according to the Government), in approving and paying for Medicare patients.

Hospitals are unable to finance care over a long period without the $350,000,000 that was advanced for the purposes of current financing, said Mr. Kauffman. "We continue to need those funds."

H.A.D.

—from *Medical Tribune*, March 7, 1973

ORIGINAL ARTICLES

Professor Fontana here offers a practical handbook of dermatologic problems in children.

Allergic Dermatitis in Children*

Vincent J. Fontana, M.D./New York

The more common skin diseases which the physician will encounter are: atopic dermatitis, contact dermatitis, allergic urticaria, and skin eruptions of various types thought to be due to a sensitization phenomenon. Atopic dermatitis, which is one of the more frequently encountered skin problems in pediatric practice, has been called infantile eczema, atopic eczema, allergic eczema, and in the older child nummular eczema and neurodermatitis. Eczema is a descriptive term that could be used for any inflammatory dermatosis where more specific diagnosis is wanting. "Neurodermatitis" is a nebulous term often used as a wastepaper basket diagnosis to describe chronic dermatosis of unknown etiology, usually seen in the adult.

Atopic eczema

"Atopy" means an inborn allergic predisposition (in human beings) identified by a strong hereditary linkage. Infantile eczema or atopic eczema usually becomes manifest between the second and sixth month of life. This type of dermatitis in infancy is the most common earliest manifestation of allergy, and has been included in the eczema-asthma-hayfever complex syndrome.

Should eczema be included in this allergy syndrome? No one has proposed an acceptable basic underlying mechanism responsible for this dermatitis. Seventy to seventy-five per cent of these children with eczema have positive family history of allergy and many eventually develop into the hayfever-asthma syndrome. Sedlis has noted that in the severely eczematous child, 36 per cent develop wheezing, whereas in the moderately affected eczematous patient, only 16 per cent were observed to develop wheezing.

Infantile or childhood eczema involves not only the epidermis but also the vascular layer of the cortis. In infants, lesions are erythematous, papular, and weeping, usually implicating the cheek areas, the face, neck, and behind the ears. There is oozing and crusting of the lesions. At this stage, the lesions are more likely to be concentrated on the head and body, rather than on the extremities. As the child advances in age, the affected areas include the flexor surfaces of the upper and lower extremities, in addition to the face and neck. With chronicity there comes lichenification and hyperpigmentation in the antecubital and popliteal areas of the extremities.

Pruritis is a major symptom of the disease and is a problem in management. It may be mild or very severe, occurring intermittently and resulting in excessive scratching, restlessness, sleeplessness, and irritability. The itching brings on scratching of the areas and the creation of new lesions and a flare-up of the already existing eczematous eruptions. In some cases, the itching is so severe that the excessive continuous scratching leads to an inflammatory reaction with excoriation, bleeding, and subsequent infection. Hence we have a cycle of itching, scratching, and lesion formation. Infection is an important complication of this disease, produced by the contamination of the open epidermis. This impetigo-like eczematous lesion causes the patient

*Read before Sections on Allergy and Dermatology, 207th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 13, 1973. Doctor Fontana is Professor of Clinical Pediatrics, New York University Medical Center, and Director of Pediatrics and Pediatric Allergy, St. Vincent's Hospital and Medical Center of New York.

additional discomfort directly related to the associated complicated infection.

In spite of our meager knowledge concerning the causes of the rash, a number of factors are known to influence the course of eczema. One may consider them "trigger" factors affecting the day-to-day appearance of the skin lesions. Some of these factors include: bacterial, viral, or fungus infection, particulate matter, and contactant irritations such as dust, inhalants, foods, temperature and humidity, emotional or physical stress, and drugs.

Children with atopic eczema have a relatively high incidence of positive skin tests by scratch or intradermal testing with the common inhalants and foods. A high proportion show blood or nasal eosinophilia. The skin of the eczematous child does not respond to stimuli as does the normal skin. When the skin of an atopic patient is stroked, vasoconstrictor response is noted. This is called "white dermatographia." With intradermal injection of acetylcholine, a delayed blanched reaction is exhibited. This is a parodoxical reaction to acetylcholine. These children also manifest abnormal sweat patterns. The atopic individual does not appear to do very well during humid weather, and studies have indicated a dysfuncion of the sweat duct in this type of patient. There is a definite inability on the part of these children to adapt to temperature changes.

The significance of positive skin tests, whether by scratch or intradermal, in the diagnosis of eczema is questionable. A positive skin test with a food does not necessarily mean sensitization. The traditional concept of a positive skin response to the allergic patient being clinically significant of specific allergy must be questioned. The skin of the allergic patient may possibly be more reactive than that of the non-allergic individual. With reference to the child with eczema, non-specific provocativeness of the eczematous skin must also be given consideration. The value of the skin test rests on the alleged parallelism between a skin test and the so-called shock organ. This concept is based rather heavily on clinical experience and can certainly be challenged. The unreliability of skin test with food allergens may be due to inadequate technics available today in preparing food allergens which are responsible for a specific clinical response.

All the skin testing, both direct and indirect, with food allergens in its present state must be considered of limited value. Evidence to incriminate foods as a causative agent in infantile or childhood eczema can rarely be related to the ingestion of a specific food allergen.

The successful treatment of childhood eczema is dependent on a complete therapeutic approach to *all* aspects of this disease. The physician must recognize the various factors responsible for this dermatitis in addition to the care and treatment of the local skin rash itself. The treatment should be as simple as possible and should attempt to alleviate the anxiety caused by the chronic skin condition. Reassurance and specific instructions to the patient and parents will greatly assist in the management of the eczematous child. Management procedures should include environmental control of inhalant allergens as well as the avoidance and elimination of all contactants and irritants to the affected skin. Local skin therapy should be appropriate to the morphologic stage of the lesions and the presence of infection. Supportive therapy must be given to avoid scratching of the lesions. Immobilization of the child may be necessary to prevent scratching. Dietary restrictions of foods, (if they have been incriminated on a clinical basis) may be required and hyposensitization therapy should be tried if indicated.

Be sure that there is no co-existing skin problem complicating the eczematous lesions. The more common skin rashes that may complicate the eczematous condition are superimposed impetigo-like infections, contact dermatitis, moniliasis and seborrheic dermatitis. Unless these co-existing dermatosis are recognized and treated, therapy will be ineffectual. Seborrheic dermatitis is one more common

skin eruption which may co-exist with childhood eczema and can be treated with Selsun® or Fostex® cream. Seborrheic dermatitis and eczema must be recognized and differentiated.

The itching and scratching phenomenon is important in the production of new lesions and the exacerbation of existing eczema. To prevent the pruritis associated with this disease, the physician must consider antihistamines by mouth, appropriate dosages for the age. The sedative effect of these drugs is helpful in managing the irritable and uncomfortable patient. Antipruritic agents such as Periactin® and Temaril® have not been found effective. Their usefulness remains questionable in the severe cases of pruritis. The hydroxyzines, such as Atarax,® have proved to be most effective antipruritic agents. Its antihistaminic and antiserotonine actions are helpful in alleviating discomfort. The tranquilizing effect of the drug has also been found to be most beneficial. When immobilization becomes necessary (to keep the child from scratching), cuffs can be used around the elbows to prevent flexing. The use of occlusive devices to cover the hands to prevent excoriation of lesions is also a most helpful procedure.

Poison Ivy Dermatitis

Poison ivy dermatitis is one of the common types of contact dermatitis. These lesions are caused by the Rhus plants and affect as many as 70 per cent of the American population. Rhus plants, toxicodendron radicans, are the principal agents causing this sensitization reaction. Poison oak is more predominant in the West Coast. Poison ivy occurs throughout many areas of the United States. There is a cross-sensitivity between these plants and the antigens of the two plants are said to be similar in chemical configuration. The antigenic components responsible for the skin reactions are catechols. Poison ivy dermatitis can be acquired only by intimate contact with the antigenic substance of the plant.

This type of dermatitis falls into the delayed reaction type with the antigen assuming a haptene configuration consisting of the plant material and tissue protein. The delayed variety of sensitization response produces no detectable antibody and no histamine or histamine-like substance underlying the immunologic response. First signs of poison ivy are usually limited to the actual areas of contact with the inciting allergen. The severity of the disease is dependent on the degree of exposure and sensitivity of the patient. Lesions of poison ivy dermatitis can appear soon after contact and can be confined to the areas of direct exposure such as the hands, face, neck, and legs. Secondary lesions may appear on the unexposed surfaces of the body through transference by hands or clothing. The regions of the clothing, such as the genital area, are commonly involved since the irritant is carried there by the hands. This type of contact dermatitis is self-limited and, in the absence of complications, usually lasts for about two weeks.

Symptomatic treatment of poison ivy dermatitis includes local and systemic medications depending on the severity of the disease. During the initial acute stages with vesiculation, exudation, edema, and severe itching, the application of saline or Burow's solution compresses and soaking help alleviate the itching and assist in the removal of crust and debris. In the less acute phases of the disease and in its early stages, attempts should be made to remove the irritant from the skin by washing the exposed areas with soap and water. This can be followed by the application of calamine lotion without phenol. Superimposed infection is treated with antimicrobial topical medications. If the infection is severe, consideration could be given to an oral antimicrobial. To relieve the itching, antipruritic agents may be given orally. Tranquillizers such as Atarax® are also effective in alleviating the itching and anxiety resulting from the disease. Steroid therapy may be used for short periods of time in the very acute and disabling cases of poison ivy dermatitis.

The antigens used in hyposensitization have consisted of Rhus oleoresin, 3-n-pentade-

cylcatechol. Actually, the true effectiveness of hyposensitization therapy in Rhu dermatitis still remains questionable. The only satisfactory method for preventing poison ivy dermatitis is the avoidance of the plants which cause it.

Diaper Rash

The most common type of dermatitis in the infant may well be the commonly called diaper rash (ammoniacal diaper dermatitis). This is characterized by an erythema on the surfaces of the buttocks, a papular vesicular lesion which, when broken, may become umbilicated or ulcer-like. This reaction is not due to a sensitization phenomenon but is primarily an irritative chemical response. The causative factor is the production of ammonia in the urine by the urea-splitting bacteria which originate in the intestine and affects the skin around the buttocks.

A simple diaper rash may not be quite so simple and can become a serious problem to both mother and physician. It is, of course, a very bothersome state of affairs to the infant. The complications are unfortunately iatrogenic in nature. A super-imposed infection in the diaper area can cause a severe type of dermatitis leading to pustulization, ulceration, and scar formation. The promiscuous use of externally applied medication used by the mother may result in a severe dermatitis worse than the original diaper area dermatitis. This complicating dermatitis is, in a sense, a "dermatitis medicamentosa." In an attempt to clear up the diaper rash, the mother oftentimes may apply a multitude of ointments and salves, lotions, powders, and baby oils. She uses these substances, prescribed by the physician, not knowing that she is creating a more bothersome dermatitis. The excessive application of topical medications such as baby oils, powders and lotions, ointment, and creams should be avoided in the treatment of diaper rash.

In differential diagnosis, the physician must also consider the possible existence of intertrigo. This rash involves the creases of the body, primarily those skin surfaces in contact with one another, especially the inquinal area, the cleft between the buttocks, and the fleshy folds of overweight children. The lesions are usually evident during hot weather months and are associated with maceration and erythema of the affected areas. Perspiration, heat, and friction are the inciting agents in this type of dermatitis.

The physician must also consider moniliasis in the differential diagnosis of the lesions in the diaper area. Efforts to achieve good results in diaper rash may be impeded by a complicating or already existing moniliasis. Moniliasis is caused by the yeast-like fungus, Candida albicans. The rash occurs in the intertriginous areas of the body, has an erythematous moist surface with borders that are usually sharply delineated. The diagnosis is usually established by the clinical appearance of the dermatitis and by demonstrating the organisms and cultures of the scraping of the lesions. Effective treatment consists of using Nystatin® or microstatin in ointment or tablet form. Venetian violet may also be applied by local application.

Treatment of a diaper rash should be directed toward the prevention of complications such as those caused by the promiscuous and excessive applications of ointments, creams, powders, and baby oils. Efforts must be made to prevent superimposed infections which may cause ulceration and subsequent scarring. The following hints should prove helpful in treating the child with a diaper rash:

1. Frequent diaper changes with exposure of the affected areas to air and dry heat from an electric light bulb. Caution must be emphasized to prevent burns from contact with the light source.

2. Proper skin hygiene with mild soap and water.

3. The bedclothes should consist of non-irritating materials, soft and unstarched.

4. The application of multispectrum topical antibiotic in the presence of infection and the use of preventives such as Diaparene® when washing diapers and Dennison® diaper liners which may be helpful in avoiding the breakdown products of ammonia that are responsible for the diaper rash.

Contact Dermatitis

Contact dermatitis or allergic contact eczematous dermatitis is one of the more frequently encountered conditions affecting the skin of children. This is one of the few diseases which can be cured promptly after removal of the causative agent.

Contact dermatitis is caused by an allergen coming into contact with the epidermis resulting in a spectrum of skin eruptions ranging from a simple erythematous rash to the more severe urticarial and bullous formations. The usual form of contact dermatitis may be manifested by a delayed reaction with the appearance of the rash within 24 to 48 hours after the sensitizing substance has made external contact with the skin. Any human being can be sensitized to develop contact dermatitis with adequate concentration of the allergen and sufficient exposure to lower normal individual skin thresholds.

Lesions in the acute response of contact dermatitis may consist of erythema, edema, formation of blisters, and if superimposed infection is evident, pustulation and weeping. In time, if the contact dermatitis is not properly managed, the condition will become subacute, when the edema and erythema are less prominent, and crusting with associated itching, scaling, and some oozing becomes the more characteristic lesion responsible for the patient's discomfort. If the causative agent is not uncovered and the disease continues over months or years, the rash may assume an eczematous appearance with lichenfication and occasionally hyperpigmentation of the affected skin.

In a discussion of contact dermatitis, the etiologic agents may fall within two categories: The first consists of substances which cause skin reactions because of an irritant quality they possess due to physical or chemical characteristics. These skin eruptions are usually of the immediate type rather than the delayed. Second are substances which cause dermal changes due to cutaneous sensitization rather than by their inherently irritating quality. These are the true sensitizers which produce a specific immunologic response.

Soaps are commonly the cause of a contact dermatitis either due to the irritant or allergenic properties of the added medicaments, perfumes, fatty acid constituents, or the coloring materials that are in the soap used. Strong detergents that may be left in clothing after washing can cause a contact dermatitis in the sensitive skin of an atopic child. Salicylanilides used in soaps and topical preparations are degraded into sensitizing compounds when exposed to sunlight and can cause a photo-allergic contact dermatitis. At present the most common offending substances are the halogenated salicylanilides and related compounds used in soaps, cosmetics, and medicated topical preparations. The use of antibacterial soaps which contain one of the salicylanilides has been established as a cause of photodermatitis.

Practically every drug that is applied to the skin can become a potential allergen in the susceptible individual. Medications in salves and ointments, applied to the skin of the patient, are the more commonly encountered drugs responsible for sensitization of the skin. These include the topical medications such as the caine derivatives (benzocaine, and tetracaine), the coal tars, salicylic acid, mercury, mineral oil, antihistamines, sulphur, and penicillin. In my practice, I have found that a variety of baby oils that are routinely applied to the skin of an infant are responsible for rashes. This reaction can be due to the irritating effect of the oil, the antiseptic in the particular product used, or an inflammatory flareup of an already existing rash by the continued application of baby oil to the skin. The indelible dyes in lipstick and the synthetic resins in nail polish may also fall into this category of contactant dermatitis due to drugs.

Paraben® allergy is a common cause of an intractable type of contact dermatitis. Paraben® esters—methyl, ethyl, propyl, or butyl p-hydroxybenzoate—are incorporated in most dermatologic and cosmetic creams or lo-

tions as preservatives. Patients allergic to the Paraben® esters give a typical history of long standing progressive, chronic dermatitis nonresponsive to the proper application of steroid creams and lotions. The usual concentration of Paraben® in corticosteroid creams and lotions is less than 0.5 per cent. Concentrations up to 5 per cent in white petrolatum are necessary for reliable diagnostic patch testing. Special attention and recognition of this iatrogenically induced type of contact dermatitis will prove gratifying for both physician and patients.

The chemical or dyes used in the processing of fabric may cause contact dermatitis. Paraphenyl-enediamine, a dye (frequently incorporated in fabrics and leathers) deserves consideration in suspected cases of skin sensitivity. Cotton or wool fibres in themselves are not the usual sensitizing factors in this type of disease. The presence of heat, friction, and associated perspiration assists the release of the dye onto the sensitive skin.

Additives And Contaminants

With the increase in human drug consumption and with the vast variety of artificially flavored foods ingested daily, a physician who is questioning the possibility of a skin allergy in his patient must also consider the possibility of a reaction to an additive or a food contaminant. There is an increased tendency to include color additives containing coal tar derivatives or natural dyes from plants or animals as well as inorganic or synthetic pigments to foods. The potential allergenicity of these products must be recognized by the physician in his attempt to uncover an etiologic factor responsible for allergic symptoms. Preservatives, such as sodium benzoate, acetic acid, lactic acid, citric acid, and propionates, can cause specific symptomatology resembling food allergy. These drugs are used in the manufacturing of frozen and canned foods as well as in a multitude of beverages. The complicating sensitization to an additive or preservative in a food may make the search for a food allergen difficult unless the physician is alert to this problem.

A surprisingly large number of foods and drugs contain yellow #5 azobenzine dye, a chemical additive, as well as other additives. Over 2,700 additives have been compiled and classified by the National Research Council. A considerable number of these popular additives such as tartrazine and benzoate are used daily by manufacturers without any information available to the prescriber or the consumer. In most cases, the actual dye used is a trade secret and dyes such as tartrazine or yellow #5 are at times added without being listed on any label. Cases of asthma and urticaria have been attributed to this yellow #5 dye, a coloring agent used in many of the commonly used medications. Coloring material in chewable vitamins and in artificially flavored juices such as Hawaiian Punch® and Kool-Ade® have caused allergic reactions in the sensitive patient.

In view of these recent reports, it would seem useful and valuable to the physician and certainly of benefit to the patient that the Food and Drug Aministration require full disclosure of all additives in foods, beverages, and drugs. These detailed declarations of additives may prevent allergic reactions which are presently going unrecognized.

The vegetable gums such as karaya, tragacanth and arabic are usually in foods to add bulk, thickness, and heaviness. They are found in fillings in candies, cream cheese, whipped creams, cake icings, toothpastes, commercial potato salad, mustard, jello, wheat cakes, cupcakes, and chewing gums. Condiments, spices, and other food accessories can be irritating and sometimes produce cutaneous, gastrointestinal, and other allergic reactions in the atopic individual. Among the more important spices are mustard, pepper, ginger, cinnamon, cloves, nutmeg, and thyme. Vanilla, almond, mint, and peppermint are all food accessories that should be considered in an allergic diagnosis involving a food factor.

The addition of antibiotics, particularly penicillin, in poultry, milk, cattle, and injectants are another aspect of the sensitization phenom-

ena which may be included in a possible solution of a food allergic problem. Pesticides used in farming and animal feed may further complicate the picture of a food allergy. It must be understood, however, that reactions to food additives, preservatives, and pesticides are not common but must be thought of in the unusual and difficult case to diagnose wherein a food or drug is suspect as a cause of the patient's dermatitis.

130 West 12th Street

Health Care in Jails

"The prisoner had been shot in the leg during the arrest. He was placed in a cell but at no time was he charged with any crime. The custodian of the jail refused to call a physician in spite of the fact that the leg became infected. A judge released the prisoner and he obtained medical attention, but the infection was so widespread that the leg had to be amputated to save his life."

The above incident, cited in the *Journal of the American Medical Association,* is one of the more extreme examples of a major problem in the United States: medical care in jails.* And the problem has spurred the AMA to map a three-year program aimed at upgrading that care.

In a national survey conducted jointly with the American Bar Association, the AMA found, among other things: Medical care is virtually non-existent in many jails; in most of the jails, non-medical personnel dispense prescription drugs to inmates; facilities for mental patients, alcoholics, or drug addicts are available in less than 2 out of 10 of the jails* surveyed.

Public apathy, local government officials, and the medical profession came in for criticism.

Dr. Carl A. Hoffman of Huntington, West Virginia, President of the AMA, noted that "the gross inadequacy of health and medical services for prisoners surfaces periodically sometimes through a press expose, but then the problem is forgotten again."

"It is a problem easily ignored by the public unless it receives continual emphasis," Dr. Hoffman added. The ABA-AMA joint operation was designed to give it that emphasis. (The two organizations also teamed in 1930 to urge the now common use of psychiatric services by the courts and correctional institutions.)

The new plan calls simply "for a long-term program to initiate health care programs in jails,* prisons, and juvenile detention facilities where they do not exist and to improve them where they do exist," the AMA President said.

First step in the campaign was a survey of 2,930 jails*. The 1,159 usable responses returned showed that 65 per cent of the responding jails had *only* first aid facilities; 17 per cent had *no* internal medical facilities for the mentally ill, drug addicts, or alcoholics. In most jails there are no formal arrangements with physicians to provide care; doctors are just called when some jail official thinks they are needed. In four out of five jails non-medical personnel do the dispensing of medications.

"We propose a program that will *involve* local doctors and local medical organizations," Dr. Hoffman said. "A program where the physician and medical society will make their own commitments to improving medical and health care in jails."

*References here are to jails, not prisons.

Xeroradiography seems to be a safer, simpler method of mammography as here indicated.

Xeroradiography Diagnosis of Breast Diseases

Daniel S. Cukier, M.D./Hackensack

Mortality rates from cancer of the breast have not changed significantly in the past thirty-five years.[1] Prognosis is often affected by the size of the primary lesion and by the status of the axillary lymph nodes.[2] Generally, a small lesion with negative axillary lymph nodes carries the most favorable prognosis. Mammography complements physical examination in the effort toward earlier diagnosis, and thus favors discovery of early clinically occult lesions.

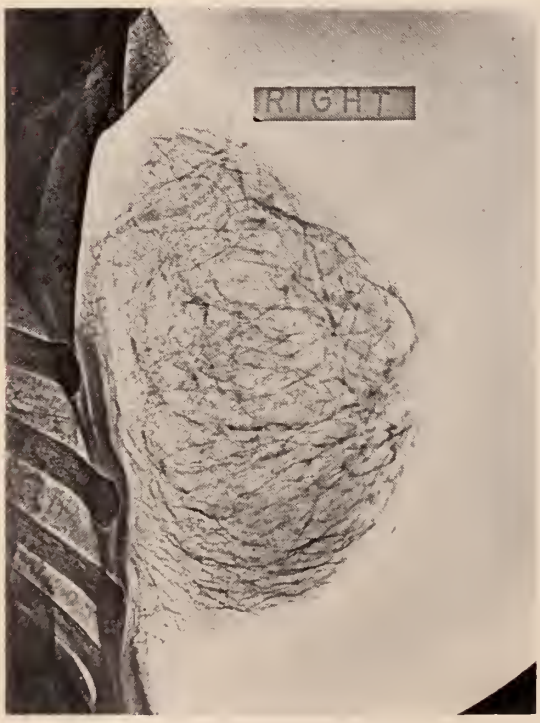


Figure 1—*Normal* premenopausal breast.

*Xeroradiography equipment is available at Saddle Brook Hospital in Saddle Brook and in the offices of radiological groups. Dr. Cukier has further information.



Figure 2—*Normal* postmenopausal breast with residual glandular tissue (arrows).

Mammography has gained wide acceptance for the differentiation of benign malignant lesions. It confirms the clinical impression of benign disease and detects the occult breast cancer. However, the procedure is time con-



Figure 3—*Adenosis* (mammary dysplasia). Dense tissues (large arrow) are secondary to connective tissue hyperplasia. Coarse calcifications (small arrow) are prone to occur.

suming and involves considerable irradiation to the patient. Furthermore, in some breasts it has a generally low index of reliability, especially in the small dense breast and in the 20 to 35-year-old age group with compact breast tissue.

Xeroradiography*,[3] on the other hand, appears to be a superior method for the diagnosis of breast diseases. It greatly reduces irradiation to the patient, is rapidly performed, and accentuates significant structures, aiding in the ease of interpretation. By enhancement of edges at regions of discontinuity in density within the breast, veins, calcifications, fibrous strands, and margins of masses are rendered more visible. Thus, in addition, xeroradiography is more readily suitable for screening programs.

Xeroradiography involves x-ray exposure with the creation of a latent image on a charged selenium surface by a photoelectric process. The image on the selenium photoconductor is then made visible by development with electrically charged blue toner particles and transferred permanently to a sheet of paper. The interpretation is then made by ordinary light rather than conventional transillumination through a view box.

Mammary dysplasia reveals a mixed xeroradiographic picture of cystic disease and fibrosis. Occasionally, coarse calcifications will present, readily diagnosed as benign.

Cysts and fibroadenomas are seen as dense masses with sharp borders. These often displace adjacent breast fat creating a less dense "halo" surrounding the mass. Fatty tumors (lipomas, adenolipomas) have sharp margins



Figure 4—*Cystic disease* (fibrocystic disease). Cysts of varying sizes (arrows) as well as cystic dilatation of ducts are present.

and are less dense than the surrounding breast tissue which they displace.

Cancer is identified by one or more of the following features: (1) a mass, (2) tumor calcifications, (3) an abnormal ductal pattern. The mass may be spiculated (scirrhous carcinomas) or nodular with partially ill-defined borders (medullary carcinomas). Tumor calcifications can be distinctive and are identified in approximately 40 per cent of all cancers. They are often of small size (grain-like), irregular in contour, and clustered within a small area. Typically, but not always, they are located within the mass of cancer, although they may be widely separated in clusters such as seen with comedo carcinoma. An asymmetric collection of ducts in one breast or segmental prominence will often lead to the discovery of an occult cancer. Secondary signs for the detection of cancer, such as increased vascularity, edema of the skin, and skin retraction are useful but not pathognomonic in themselves.



Figure 5—*Fibroadenoma* (inside arrows) has gently lobulated, sharp margins and is compressing adjacent fat tissue.



Figure 6—*Lipoma* is sharply demarcated (arrow) and has a fat density which displaces adjacent tissues.

Blunt trauma, with resultant hematoma, and biopsy sites may simulate the appearance of carcinoma, but are differentiated by history and physical examination.

Axillary lymph nodes are readily seen on the xeroradiogram, and, when of large size, may suggest metastatic disease.

Conclusion

Xeroradiographic examination of the breast offers a technically superior study to conventional film mammography. In addition to re-



Figure 7—*Scirrhous carcinoma* displays a prominent central density (large arrow) with radiating peripheral spicules (small arrow).

duced irradiation of the breast, it offers rapidity of performance and increased ease of interpretation. Its technical characteristics make it a more suitable study for mass screening than conventional film mammography.



Figure 8—*Medullary carcinoma* (large arrow) is lobular with some loss of definition. Multiple irregular calcifications (small arrow) of varying sizes are present.

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35 Pangborn Place

The family of our late Editor, Henry A. Davidson, M.D., has requested that, in lieu of other tributes, donations be made in his memory either to the Academy of Medicine of New Jersey or to the Essex County Mental Health Association. It is planned to initiate an annual symposium in Dr. Davidson's honor and donations should be made to the Educational Fund of the Academy of Medicine of New Jersey, 2424 Morris Avenue, Union, New Jersey 07083.

An obscure disease characterized by pulseless, diffuse vascular symptoms and gastrointestinal complaints may turn out to be Takayasu Disease. Read on and learn.

Pulseless Disease Producing Abdominal Angina and Simulating Anorexia Nervosa*

Nathan Frank, M.D./Jersey City and M. Jeffrey Frank, M.D./Washington, D.C.

A female patient with "pulseless disease" accompanied by unusual symptoms was seen by the authors. Since the classic features of arteriosclerotic disease in this 36-year-old menstruating female were absent, the authors fear that similar cases are more prevalent than has been reported in the literature and that physicians should be made aware of this possibility.

Pulseless disease was first described by Takayasu, a Japanese ophthalmologist who noted the absence of radial pulses in women who developed progressive blindness. This has been designated by various terms, but the most frequent are "pulseless disease",[1,4,5] "Takayasu's disease"[2] and "aortic arch syndrome."[3] The clinical finding that serves to attract the attention of observers was the absence of pulse and/or blood pressure in the upper extremities. Carotid pulsations were frequently diminished or absent. Classically, one or more of the major arteries arising from the aortic arch was compromised by the development of stenosis or thrombosis.

Over the years, reports have indicated that the entire aorta and all its branches have been affected in "pulseless disease." As a result, symptomatology referable to the brain, eyes, ears, extremities, heart, and abdominal viscera has been noted. Carotid disease produces cerebral manifestations[6] such as headache, vertigo (particularly when arising from the horizontal position), convulsions, hemiplegia, and hemiparesis. Eye symptoms include blindness, scotomata, diplopia, and photophobia. Although changes in the auditory mechanism are rare, deafness and tinnitus have also been described.

Dyspnea, angina pectoris, and peripheral vascular insufficiencies have been observed as cardiovascular manifestations of the disease. Color, temperature, and/or skin changes occur in the extremities as signs of vascular compromise. Occasionally patients complain of intermittent claudication in the arms.

The following case report is being presented to alert physicians carefully to observe apparently unrelated signs of vascular compromise. Note that in this patient (1) a major portion of the entire arterial vasculature was involved, (2) anatomical correlation for abdominal angina was present, and (3) the initial diagnosis masqueraded as "anorexia nervosa."

A 36-year-old female was transferred to the Thomas J. White Cardiopulmonary Institute (Jersey City, N.J.) from the Jersey City Medical Center. Early history noted a heart murmur at age 3 and two episodes of fever and polyarthritis at age 8. A diagnosis of rheumatic fever was made at that time. At age 17, her first pregnancy was complicated by congestive

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heart failure requiring hospitalization. Two subsequent pregnancies were relatively uneventful.

For two years prior to admission, the patient had symptoms of dyspnea and orthopnea. There were significant episodes of angina and intermittent claudication of the lower extremities. She also complained of epigastric pain radiating to the lower abdomen, aggravated by the ingestion of food. Associated symptoms were nausea, vomiting, anorexia, and a forty pound weight loss. The patient had always been a tense, nervous individual, but her gastrointestinal symptoms had increased in severity for the preceding six to eight months prior to admission.

She was admitted to the Jersey City Medical Center because of increasing dyspnea and cyanosis. Examination revealed unobtainable blood pressure in the upper extremities, and a systolic ejection murmur at the base of the heart radiating to the neck. The patient was transferred to the Cardiopulmonary Institute after ten days of hospitalization.

On admission, the patient was anxious and cachetic in appearance. Blood pressure was unobtainable in all extremities, Brachial, radial, popliteal, dorsalis, and posterior tibial pulses were not palpable. Only the femoral and carotid pulses were perceived. Examination of the heart showed no cardiomegaly but there was a Grade III/VI harsh systolic ejection murmur radiating from the base to the neck. The second heart sound was split physiologically.

On the second hospital day, cardiac catherization was unsuccessfully attempted. During this hospitalization the patient experienced no relief from her gastrointestinal symptoms. She became uncooperative, and continued to lose weight. A diagnosis of anorexia nervosa was made. After three weeks of a fruitless hospitalizaton, the patient signed her release.

One month later she was readmitted complaining of pain and limitation of motion of the right hand. Examination revealed a pale, cold, edematous hand in addition to atrophic overlying skin, dependent rubor and increased venous filling time. In the lower extremities there was skin atrophy, plantar ischemia and dependent rubor of the feet. All toes were gangrenous.

Pertinent laboratory data: cholesterol—135 to 145 mg per cent, triglycerides—93 mg per cent, total lipids—875 mg per cent. Hemogram showed microcytic hypochromic anemia with gauiac positive stools. Urinalysis, electrolytes, serum proteins, PBI, rheumatoid factor, L.E. preps, (three specimens), blood cultures, VDRL, and Reiter's test were all normal or negative.

Chest x-ray demonstrated diffuse calcification of ascending and descending aorta and sinus of Valsalva. The heart was not enlarged. Abdominal films showed calcification of the abdominal aorta, iliac, and femoral arteries. An upper G.I. series was normal. ECG revealed non-specific ST and T wave changes suggestive of myocardial ischemia.

The pathologic changes in the patient's hand were attributed to a causalgic state ("shoulder-hand syndrome"). A series of stellate ganglion blocks offered slight relief of pain. During this final hospitalization, the patient continued to have nausea, vomiting, loss of appetite and weight. Stools were positive for blood although the vomitus was negative. An upper G.I. series was normal. On the day of the patient's death there was progressive abdominal distention and rigidity before she rapidly went into shock and expired.

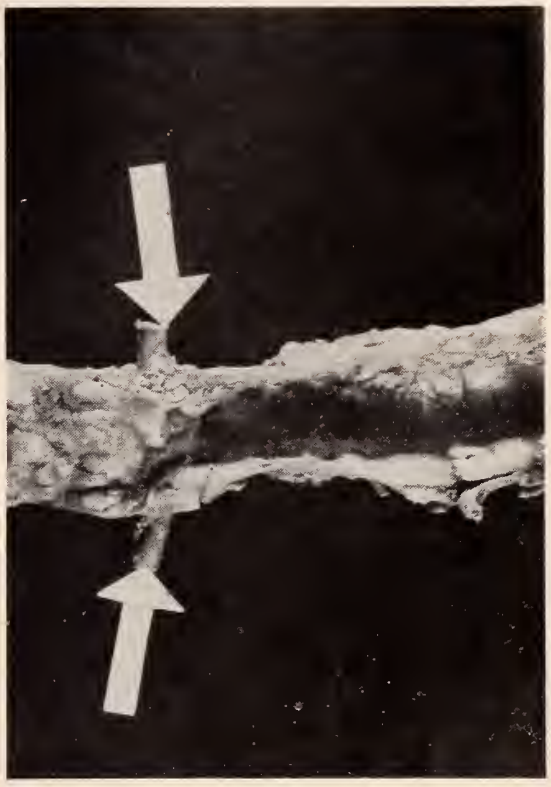


Figure 1

Autopsy Finding

There was 200 cc of bloody fluid in the peritoneal cavity. The small intestine was markedly distended and necrotic. There were areas of mucosal necrosis and hemorrhage extending from the lower jejenum to the ileum. The mesenteric arteries were narrowed both at their origin and throughout their entire course. The large bowel was normal.

The chordae tendinae of the mitral valve were thickened, shortened, and fibrotic. The aortic valve cusps were fused and sclerotic; the orifice was slightly narrowed. In addition to extensive calcification, the aorta showed dramatic intimal connective tissue proliferation. At the level of the renal arteries the lumen was almost totally obliterated by collagen fibers (see figure 1, arrows designate renal arteries).

Representative sections are demonstrated in figures 2 and 3. Coronary arteries in right and left ventricles respectively are shown. There is extensive adventitial collagen proliferation in addition to subintimal fibrosis in the muscularis layer. Atheromatous plaques or thrombus formation are conspicuously absent. No giant cells or granulomata are present.

Discussion

Although the name "pulseless disease" seems appropriate, there still exists a great deal of uncertainty regarding a true descriptive term for the disease. The most pathognomonic



Figure 2



Figure 3

physical sign is absence of pulse in the neck and upper extremities. A more appropriate designation for the disease might well be "diffuse aortic obliterative disease." This latter term could include those patients whose entire aorta is involved (as in our patient) and those where only the major aortic branches are diseased. Although there have been more than one hundred reports in the world literature, only a few have included definitive autopsy findings. It is our feeling that many of the cases (other than those due to syphilis[9]) would have demonstrated diffuse vascular disease rather than limitation to the aortic arch.

From an etiologic point of view, several diseases could produce a similar clinical picture. In the Orient, tuberculosis and syphilis are the most frequent causes. In this country, atherosclerosis would probably be considered the most common mechanism. Thromboangiitis obliterans (Buerger's disease), giant cell arteritis, and collagen vascular disease could also conceivably produce this syndrome.

Yet the autopsy findings and clinical course in our patient did not demonstrate classical arteriosclerotic changes nor any evidence of other disease. Thus, we would conclude that the precise nature of this disease still remains obscure and has yet to be defined.

Pulseless disease is probably much more prevalent than has been actually recorded. This assumption is based on our experience that absence of pulse has often gone unrecognized or has simply been ignored. In the present instance, several fairly competent observers recorded pulse rates at the radial artery when in actuality the pulse had been completely obliterated. Other sources of error also lay in their failure to take blood pressures in more than one extremity, or examiners were actually counting their own pulse.

The cardinal symptoms and signs depend on the vessels involved. In addition to coronary artery pathology, the unusual feature in this patient was the compromised mesenteric artery. Mesenteric thrombosis, the actual termi-

nal event, explained the abdominal angina, anorexia, weight loss, and gastrointestinal bleeding so prominent in the clinical course. Marked cachexia and adamant refusal to eat convinced many observers that the patient had anorexia nervosa. Moreover, there was arterial vascular insufficiency of lower extremities (note intermittent claudication and gangrene of the toes). This finding would not be expected in the so-called pure "aortic arch syndrome."

Summary and Conclusions

A patient with pulseless disease and diffuse vascular involvement with apparently unrelated symptoms was described. The authors noted that prominent in the patient's clinical course was abdominal angina and gastrointestinal symptoms mimicking anorexia nervosa. Autopsy findings revealed intimal and subintimal fibrous tissue proliferation rather than arteriosclerotic changes. The likelihood of similar unreported cases was emphasized. The etiology of this disease remains obscure and deserves further examination.

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180 Bowers Street

Bland Diets for Ulcer Patients Discredited by JAMA Report

What should the doctor aud his patient do about diets in intestinal disorders? Not much, says a report in a current (September 3) issue of JAMA. Authorized by Robert M. Donaldson, M.D., of the Boston University School of Medicine, the report says the bland, tasteless, insipid diet of the ulcer patient probably isn't helping the ulcer and should be dropped. "Those who advocate dietary restrictions for ulcer patients urge that only 'bland' foods be allowed. In general that restriction has been implemented by presenting the patient with foods of a particular color (white), consistency (soft), and taste (mild) that fit the physician's or dietitian's preconceived notion of what is 'bland.' It is clear, however, that what is considered bland in one set of dietary instructions may be different from what is permissible in another.

"There is something fundamentally wrong with an approach that assumes that the form, consistency, color, taste, and odor of a food have anything to do with the effects of that food on secretions, mucosal integrity, vascularity or motility of the gastrointestinal tract. Controlled clinical trials indicate that the kinds of food ingested have no effect on the course of peptic disease or on the quantity of acid in the stomach."

There seems to be little doubt, says Dr. Donaldson, that the ulcer patient should be allowed, after all, to enjoy his food. With a few exceptions, such as eliminating coffee and alcohol in active peptic ulcer patients, "there seems to be little need for the patient with gastrointestinal disease to become entangled in confusing dicta about what to eat."

Here surveyed are the possibilities of precoronary care facilities in a small suburban community.

Precoronary Care in a Suburban Community

Francis Wanat, M.D., Milton Landman, M.D., and Maurice Leon, M.D./Montclair

Approximately 60 per cent of deaths from coronary heart disease occur within the first hour of symptoms and happen outside of the hospital[1,2]. The admissions to three community hospitals' coronary care units in a suburban city were surveyed to determine patterns in requesting and receiving care. The three hospitals in Montclair, New Jersey, a city of 44,000, serve a population of 225,000. There are no serious vehicular transportation problems in the area. The hospitals have overlapping staffs and services. All are served by rescue ambulance squads, well trained and equipped, providing service *via* radio calls initiated through their local police departments.

Each hospital maintains a well-organized coronary care unit. Mountainside has a total of 363 beds, 12 in coronary care, and has a 24-hour active emergency room service run by a panel of practicing physicians, with one in constant attendance. Saint Vincent's has 115 beds, 5 in coronary care, and Montclair Community, 120 beds, 6 in coronary care; both have 24-hour per day house physicians.

Patients or their families were interviewed by their physician or the nurse as soon after admission to the coronary care unit as possible. Attention was paid to three time intervals: (1) From onset of symptoms to requesting medical attention, (2) From requesting to receiving medical care, and (3) From receiving medical care to admission to coronary care unit. The hospitals were surveyed from December 1971 through October 1972.

Our load includes 148 patients, of which 81 were males. Age range was 34 to 88. The mean or average times were longest as expected, more affected by extremes. The median was more representative of the central tendency. There were several modes for two categories (see chart).

All Hospitals—All Time in Minutes

	I	II	III
Median	60′	30′	60′
Mean	435.5′	80.5′	104.35′
Modes	60′	15′ and 30′	15′ 30′ and 60′

The longest delay was between the onset of symptoms and requesting aid, period I; median and mode one hour, mean 435 minutes. Once help was sought, service was given promptly, period II; the median was 30 minutes with mode peaks of 15 and 30 minutes. Patients came directly to the emergency room in many cases. The interval between receiving care and arrival in the CCU was lengthy in many cases, median 60 minutes and modes of 15, 30, and 60 minutes. The means were affected by a small group of cases with marked delays.

In previous studies, delay in the patient requesting medical attention has been related to a long decision-time created by denial or ignorance of the possibly serious situation. Effort must be made to overcome psychologic denial[3]. We cannot stress too strongly the need for public education to shorten decision time lag.

Prior physician identification of the high risk patients and education might bring this group directly to emergency rooms in a shorter time. A prior study[4] noted that those patients with known coronary atherosclerotic heart disease did not reach the hospital sooner than those without. Electrical deaths occur swiftly. Patients must arrive at a point of definitive care with the greatest of haste. Direct admission to the coronary care unit is recommended to shorten the time between receiving medical care and CCU therapy.

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230 Sherman Avenue

Runaways and Dropouts

Running away and dropping out—supposedly new phenomena among modern American teenagers—is merely following long-standing American tradition, says a report in the July, 1973 issue of *Archives of General Psychiatry*.

Each year between 600,000 and 1,000,000 teenagers run away from their American homes, says Helm Stierlin, M.D., of the National Institutes of Health.

Most early immigrants to America were runaways from Europe which oppressed and squelched them. "Once these immigrants had created a culture of their own, they gave rise to ever-new runaway and dropout movements such as advocated by Noyes or Thoreau." "Doing your own thing," a big consideration in understanding why teenagers run away, still reflects the individualism and relative lack of social responsibility of earlier American generations, says Doctor Stierlin. But the earlier Americans largely were adults, while the present ones are teenagers who ordinarily would live with their families, he points out. Dr. Stierlin cites three factors involved in today's runaways:

1. The affluence of American society makes it possible for them to survive. The girls of Charles Manson's household made "delicious" meals from the contents of garbage cans.

2. Mobility and easy access to transportation of modern society makes long-distance movement possible. Hitch-hikers' thumbs (particularly when lifted by pretty girls) can stop automobiles as if they were magic carpets.

3. Runaways reflect and exploit the breakdown in society's stability and cohesiveness.

Three basic types of home situations from which youngsters run away are aired:

1. *Binding* parent relationship, in which the parents are overly strict and set expectations for children unreasonably high.

2. *Expelling* relationship, in which parents are too permissive and actually care little about their children.

3. *Delegate* relationship, in which parents unconsciously steer their children to do things which they themselves secretly wished to do but never accomplished, such as moving away to a new and exciting strange place.

For those youngsters who are too tightly bound to their families, successful running away can signal progress rather than a setback. It reflects the increasing ability of the adolescent and his parents to live apart from each other.

This is one of the very few reports citing the association between herpes zoster and multiple myeloma.

Herpes Zoster and Multiple Myeloma

Parvin Saidi, M.D., W. E. Uhlman, M.D. and I. Goldberg, M.D./Piscataway*

The association of herpes zoster with neoplasias in general, and hematologic malignancies in particular, has received considerable attention since Craver and Haagensen's[1] review of the subject in 1932. Although the frequent occurrence of herpes zoster with the lymphomas, Hodgkin's disease, and leukemias has been repeatedly reported, and the high incidence established in several series of such patients,[2 to 10] the association of herpes zoster with multiple myelomas has received little attention. Purpose of this paper is to present a patient with multiple myeloma, in whom herpes zoster preceded the clinically overt stage of multiple myeloma, and to discuss the implications of our present understanding of this viral infection as it pertains to multiple myeloma.

A 73-year old woman was admitted to the hospital in January 1972 for evaluation of severe low back pain. She had suffered from intermittent low back pain for the preceding five years for which she had been treated with analgesics. Five years earlier she was hospitalized for diagnostic work-up of widening of the mediastinum noted on routine chest film. Tomograms, esophograms, bronchoscopy, and culture and cytologic studies of bronchial washings concluded in the final diagnosis of chronic inflammatory changes of right hilum, probably old healed tuberculosis. During this hospital admission, the patient developed severe radicular pain involving the lateral and posterior aspect of the lower half of left chest, followed, after 4 days, by the typical vesicular lesions of herpes zoster. The skin manifestations subsided over a period of 10 days. Her blood count on this admission showed a hematocrit of 39 per cent, WBC of 5,000 with normal differential. Urinalysis showed no proteinuria. Fasting blood sugar and BUN were within normal limits.

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In November 1971, she sustained a fall. Subsequent to this, her low back pain became more severe, eventually requiring her present admission. At this time there was severe pain of the dorsal lumbar spine limiting her range of motion.

Laboratory findings showed a hematocrit of 32.6 per cent, hemoglobin of 11 gm per cent, RBC of 3.55×10^6 WBC of 3,900 with 39 per cent PMN and 61 per cent lymphocytes. Platelet count was 147,000; FBS, BUN, serum cholesterol, triglycerides, SGOT, SGPT, total bilirubin, and creatinine were within normal limits.

Urinalysis indicated no albumin and specifically no Bence Jones Protein. Sedimentation rate was 111 mm the first hour (Westergren method), protein electrophoresis showed total protein of 9.0 gm per cent with a spiked peak in the betagamma region (Figure 1). Immunoelectrophoresis and gel diffusion analysis

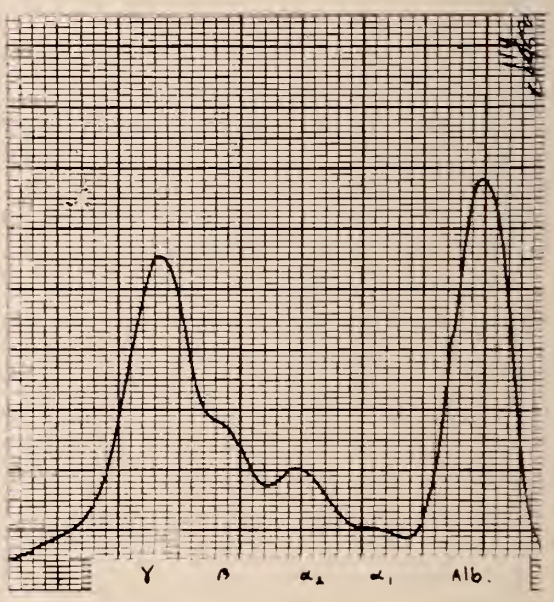


Figure 1—Electrophoretic pattern of serum proteins.

indicated a marked increase in the IgA fraction. Bone marrow aspiration showed a large number of atypical and/or immature plasma cells (myeloma cells) (Figure 2). X-ray of the spine showed minimal osteoporosis of the spine, with compression fracture of the

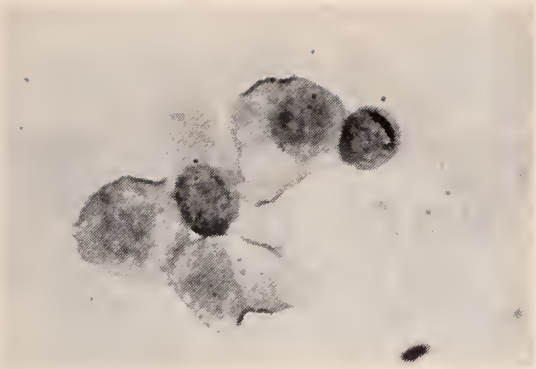


Figure 2—Myeloma cells in bone marrow. 1000x magnification.

12th thoracic and compression deformity of the first lumbar vertebra. Films of the skull and long bones survey indicated no other abnormalities. The patient was started on melphalan and prednisone therapy with excellent response in her pain. She is presently continued on maintenance melphalan therapy with careful monitoring of her hematologic response.

Herpes zoster is generally assumed to be caused by the activation of "latent" varicella-zoster virus present in the posterior ganglion cells following an original varicella infection in the patient's distant past. Presumably the active virus retraces, in a retrograde manner, its original pathway along the afferent sensory nerve, causing painful inflammatory reactions along the nerve path and vesicular lesions on the skin. Activation of the dormant virus is thought to be related to a "weakening" of host defense mechanism, and the association of high incidence of herpes zoster with aging,[11] malignancies,[5, 9] chemotherapy,[6] and splenectomy[8]—conditions proved or presumed to be related to impaired host immunity—clinically supports this view. The specific mechanism of the impaired host immunity has so far eluded investigation. In contrast to varicella infections where serum complement fixing antibodies to the virus are absent, herpes zoster often occurs in patients with high titers of such antibodies; and the level of antibody titer seems to bear no relation to the severity of zoster infection.[12, 13] In a study of six patients receiving chemotherapy, Rifkind[13] reported low antibody titers in two of the patients who developed generalized herpes zoster, suggesting that the high level of antibodies does not protect against herpes zoster, but may, at best, inhibit the dissemination of the virus.

The complement fixing antibody is believed to be of the IgG type.[13] Although immunoelectrophoresis has not been done in most of the patients reported, it is of interest that in our patient there was a high level of IgA immunoglobulins. Both IgG and IgA immunoglobulins have antivirus activity, but their specificity against varicella-zoster virus is not clear, nor do we know whether in the case of the patient reported the IgA immunoglobulins were immunologically competent. It has been suggested that the complement-fixing antibodies may be unrelated to specific defense against the varicella-zoster virus, and that the virus neutralizing antibodies might give a more correct assessment of host resistance. The neutralizing antibodies, however, have been hitherto technically difficult to measure in the case of herpes zoster. Recent reports by Armstrong, *et al.*[14] relating the severity of zoster infection to the host's ability to produce cutaneous interferon—presumably a function of the lymphocytes—may represent an important aspect of host resistance. The cutaneous anergy as indicated by absence of reactivity to dinitrochlorobenzene (DNCB) has also been cited as a factor in favor of zoster dissemination,[9] but certainly not etiologically responsible for the appearance of herpes zoster.

Local factors such as trauma, tumor, or radiation are also thought to play a role in many cases of herpes zoster,[7, 10] and lead one to speculate on the nature of the latent state of the virus and possible factors which can favor replication of the virus to the extent that local or systemic host defense mechanisms are overwhelmed.

Although multiple myeloma is often cited together with other hematologic malignancies as disorders commonly associated with herpes zoster, to our knowledge fewer than 20 cases have been reported to date,[2, 5 to 7, 15 to 21] and only two studies[2, 5] have included enough patients with multiple myeloma to suggest a statistically reasonable estimate of an incidence of 1.8 to 2.8 per cent. This is significantly above the 0.22 per cent incidence of herpes zoster in a five-year follow-up of male patients without

hematologic malignancies in a veterans hospital[5] and slightly above the incidence of 0.5 to 2 per cent of general admissions to a dermatology clinic.[22] In the present case, the appearance of herpes zoster preceded the clinically overt state of multiple myeloma, but the patient's history of back pain suggests that the myeloma process may have already started at the time of zoster infection. The appearance of herpes zoster preceding hematologic malignancies is rare but has been reported.[2] A long range follow-up study of patients without underlying disorders at the time of the herpes zoster should give valuable information with respect to the comparative "proneness" of such patients to develop malignancies; and it may be that an awareness of such a "prodromal" sign may alert the clinician to anticipate specific disorders particularly hematologic malignancies and therefore facilitate early diagnosis. The authors also believe that greater emphasis on the association of herpes zoster with multiple myeloma might allow an elucidation of the host resistance factors against varicella-zoster virus in a disorder where at least some aspects of immunity are well understood and can be studied in detail.

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University Heights

Basal Cell Carcinomas

The cooperation of physicians is requested in the referral of patients with multiple basal cell carcinomas for trials being conducted by the National Cancer Institute at the National Institutes of Health, Bethesda, Maryland.

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Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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Fear of excessive weight gain during pregnancy is deplored and the rationale of an intelligent nutritional program at that time is explained.

Nutrition In Pregnancy

Alvin Langer, M.D., Cheng Hung, M.D., and Elizabeth Munves, Ph.D./Newark*

The physician, rendering prenatal care, is often expected to give advice regarding nutrition. In the past, this advice included, among other items, statements that the patient was not eating for two, that excessive weight gain caused toxemia of pregnancy, that excessive ingestion of sodium did the same, that diuretics should be used both to limit weight gain and to reduce the possibility of toxemia, that a markedly obese patient ought to lose weight during pregnancy, that it is important to limit weight gain to preserve the figure, and that prenatal capsules will supply the additional nutritional requirements of pregnancy. In the past, we have even advised mothers suspected of having a contracted pelvis to limit food intake, in the hope of reducing the size of the new-born. Much of this advice was based not upon scientific evidence, but upon emotion or upon what is now known to be an incorrect conclusion from clinical observations. To meet the limited weight gain expected by the obstetrician, patients often went on a "crash diet" immediately preceding office visits.

Today, as a result of renewed interest in the effects of maternal nutrition upon the course of pregnancy and the fetus, we are in a more enlightened period, during which pregnancy is considered a physiologic, rather than a pathologic, state requiring limitation of dietary intake. Our focus in prenatal care should be on a normal, healthy woman giving birth to a normal weight, healthy baby. To accomplish this, adequate nutrition during childhood, adolescence, before pregnancy, and during pregnancy is essential.

Our knowledge about the effects of malnutrition during pregnancy comes from circumstantial evidence, in which essential nutrients have been eliminated or decreased by natural experiments, such as famine during wars. Data now show that reduction of protein intake during pregnancy results in birth of lower weight babies, as does a low weight gain during pregnancy or a low pre-pregnancy weight. During World War II, there was a significant decrease in average birth weight in Leningrad[2] and in Northwestern Holland,[3] both of which underwent periods of severe restriction of caloric and protein intake. Although today's Americans are generally well-fed, many do enter pregnancy with an increased risk of inadequate nutrition (see Table I). The obstetrician should consider these

TABLE I

Gravidas with Increased Risk Of Malnutrition

1. Biologically immature mothers—less than 17 years.
2. Rapid successions of pregnancy.
3. Underweight before pregnancy.
4. Low weight gain during pregnancy.
5. Overweight.
6. Low incomes.
7. Food fads because of religion, etc.

a high-risk group, requiring intensive attention to nutrition and prompt correction of any apparent deficiencies.

There is an interrelationship among all nutrients, frequently making them interdependent. For example, bone metabolism involves not only the classically implicated calcium, phosphorus, and vitamin D; it also requires a protein matrix upon which the minerals may be deposited. Protein availabili-

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ty is related to adequate fat and carbohydrates for energy, sparing protein, making it available for the matrix. All metabolic processes require certain vitamins and minerals, enzymes and hormones.

If one anticipates normal weight gain during pregnancy, it is obvious that a minimum of somewhat over 20 pounds is necessary to provide the weight needed for the products of conception and physiologic changes (see Table II). This gain is usually minimal dur-

TABLE II

Increase in Weight During Pregnancy

Baby	7.5 lbs.
Placenta	1.25
Amniotic Fluid	2.0
Uterus	2.0
Blood	3.5
Breasts	1.5
Interstitial Fluid	3.0
TOTAL	20.75 lbs.

ing the first trimester, averaging about 1.5 pounds by the tenth week. By mid-pregnancy, gain should approximate 10 pounds, and by term, average gain is 24 to 27 pounds. Weight gain in excess of that described in Table II will be deposited as fat, perhaps as a reserve for lactation, and (in the absence of specific pathology), should be considered normal.

Increased ingestion of certain nutrients is required during pregnancy. A minimum of 900 Grams of protein are stored (see Table III).

TABLE III

Additional Protein Requirements During Pregnancy

Fetus	400 grams
Placental Membranes & Fluids	120 "
Breasts	105 "
Uterus	245 "
TOTAL	870 grams

Since almost half of this is stored in the fetus, in whom most of the growth will occur in the later part of pregnancy, the demand for protein increases as pregnancy progresses. An average increased intake of 10 Grams per day of protein during pregnancy is recommended. Deficiency results in lower birth weight and a decrease in the number of cells in the placenta. Hypoproteinemia may also result in generalized edema, with weight gain which may be erroneously interpreted as a gain in fat. Such a patient may then be advised to reduce calories further, thereby compounding her problem. The cause of any weight gain should be elucidated before instituting any therapy.

About 800 milligrams of iron are stored during pregnancy, mostly during the last half (see Table IV). Approximately 18 milligrams

TABLE IV

Iron Requirements In Pregnancy

Fetus and Placenta	300 mg.
Increased Hemoglobin mass	500 mg.
TOTAL	800 mg.

per day of iron are recommended, but because only a small proportion of ingested iron is absorbed, one should aim for about 30 to 60 milligrams of iron daily.

Approximately 500 meq. of sodium are stored during pregnancy (see Table V.) There are

TABLE V

Retention Of Sodium During Pregnancy

Infant	150 meq.
Amniotic Fluid	110 "
Expanded Maternal Plasma	210 "
TOTAL	470 meq.

opposing forces leading to loss or retention of sodium during pregnancy. The increased progesterone, the increased glomerular infiltration rate, and the fetal requirements all predispose to loss of sodium. The elevated estrogen, increased aldosterone and postural edema predispose to sodium retention. A normal gravida retains only that amount of sodium needed for the products of conception and for the increase in maternal plasma. Normal gravidas can handle increased sodium intake without difficulty by decreasing aldosterone production. Although total body sodium is increased in pre-eclampsia, this increase appears to be the result rather than the cause of the toxemia. The sodium-restricted rat activates the renin-angiotensin-aldosterone sys-

tem in order to retain sodium, and this activation may push the adrenal glands to the point of exhaustion. The fetal and maternal outcome in toxemia is *not* related to sodium intake, so that one must question the wisdom of limiting sodium intake or excessive use of diuretics during pregnancy.[4]

Approximately 45 Grams of calcium are retained by the mother during pregnancy. About 30 Grams of this go to the fetus, and the remainder are in reserve for lactation. Most of that in the fetus is deposited during the last month. Since the absorption and conservation of calcium during pregnancy is unknown, 1.5 Grams per day are recommended to supply the needs. The specific calcium demand in a given pregnancy is only about 2.5 per cent of that in the maternal skeleton, so that osteomalacia should not occur unless deficient intake is combined with a rapid succession of pregnancies.

Folic acid requirements increase markedly during pregnancy. The non-pregnant requirement of 50 micrograms per day is increased at least ten times during pregnancy. Pre-anemic folic acid deficiency, as evidenced by abnormal serum folate levels or abnormal FIGLU tests, is common during pregnancy.[5] It has been suggested that even pre-anemic folate deficiency may be a factor in abortion, fetal abnormalities, and abruptio placenta, but results of different investigators of this are conflicting.[6,7] Vitamins B_6 and B_{12} are transferred to the fetus in large amounts. Deficiency of vitamin B_6 may be demonstrated by abnormalities in tryptophane metabolism, resulting in increased urinary excretion of xanthurenic acid.[8] Placentas of patients with toxemia[9] contain low amounts of vitamin B_6, and in a recent group of teen-aged gravidas described by Kaminetzky, *et al.*[10] all patients having toxemia had low blood levels of vitamin B^6. There is no evidence for increased need for such vitamins as ascorbic acid, thiamine, riboflavin, and niacin during pregnancy. Ascorbic acid is present in large amounts in breast milk, and intake should be increased during lactation. The specific needs for the fat soluble vitamins—A, D, and E—are also not clear. Little is known about needs for specific minerals and trace metals during pregnancy. Iodine is needed in increased amounts, but if iodized salt is ingested, deficiency does not occur. Zinc and manganese deficiencies have been shown to produce congenital abnormalities in animal fetuses, but deficient intake probably rarely occurs in humans.[11]

The recommended intake for various nutrients during pregnancy and lactation is shown in Table VI. These should be obtained by

TABLE VI

Recommended Daily Dietary Allowance During Pregnancy And Lactation

	Age 22-25 Adult Female (not pregnant)	Pregnancy	Lactation
Calories	2000	200 additional	1000 additional
Protein	55 grams	65 grams	75 grams
Vitamin A	5000 IU	6000 IU	8000 IU
Vitamin D	———	400 IU	400 IU
Vitamin E	25 IU	30 IU	30 IU
Ascorbic Acid	55 mg	50 mg	60 mg
Folacin	0.4 mg	0.8 mg	0.5 mg
Niacin	13 mg	15 mg	20 mg
Riboflavin	1.5 mg	1.8 mg	2.0 mg
Thiamicine	1.0 mg	1.1–1.3 mg	1.5–1.7 mg
Vitamin B_6	2.0 mg	2.5 mg	2.5 mg
Vitamin B_{12}	5 mg	8 mg	6 mg
Calcium	0.8 grams	1.2–1.7 grams	1.3–1.8 grams
Phosphorus	0.8 grams	1.2–1.7 grams	1.3–1.8 grams
Iodine	90 micrograms	125 micrograms	150 micrograms
Iron	18 mg	18 mg	18 mg
Magnesium	300 mg	450 mg	450 mg

ingestion of a well-balanced diet, and one should not rely upon supplementation by prenatal capsules. Although there is no evidence that these capsules do any harm to the gravida or her fetus, neither is there any good evidence that (with the exception of iron and folic acid) the contents are of any value. To obtain these nutrients from the diet, a minimum of 1500 calories per day are needed and most often, 2000 to 2500 calories should be ingested. The exact caloric requirement will depend upon the weight of the patient, and her activity. In general, she will require an additional 200 calories for pregnancy and 1000 calories for lactation. Table VII contains the basic food groups necessary to provide all necessary nutrients.

Prenatal evaluation should include an accurate appraisal of the woman's diet. This may be done by using a seven-day food record or a 24-hour recall. Adequate attention should be given to the following questions:

1. Are sufficient amounts of the seven basic food groups included?

2. Is a source of animal protein consumed at each meal?

3. Do excessive calories come from foods considered as empty calories, (cookies, candy, potato chips, etc.)?

4. Is there any pica?

5. Are meals routinely omitted, or is the food pattern irregular?

6. Does any medication interfere with food intake or absorption?

In the physical examination, changes in the skin, eyes, oral cavities, etc., suggestive of, but not specific for, nutritional deficiencies may be discovered. If deficiencies are expected by dietary history or physical findings, confirmation can be made by laboratory methods.[12] Such deficiencies should be corrected as early as possible. By so doing, one may influence the outcome of the pregnancy toward a healthy mother and a normal, healthy, full-size baby.

TABLE VII

Recommended Diet During Pregnancy

Type of Food	Amount/Day Pregnancy	Add for Lactation	Comments
Milk	3-4 glasses	2 glasses	Skim milk contains 90 less calories/8 oz; yogurt, plain may be substituted for milk. Equivalent calcium content to 8 oz. of milk: American cheese (1-1/3 oz.) Cream Cottage Cheese—(1½ cups—12 oz.) Ice Cream—1 pint.
Meat, Fish, Poultry	6 oz.	1 oz.	One egg may be substituted for 1 oz. of meat; 3 to 5/week should be included; lean meats, fish, or poultry are preferred; 1 oz. cheese or peanut butter can be substituted for meat protein. Dry beans, peas, may be used but should be supplemented with a source of animal protein (meat, milk, cheese).
Vegetables	2-3 servings (½ cup each)	1 cup green leafy vegetables	Include at least one serving of dark green leafy or yellow vegetables (supplies Vitamin A), such as spinach, collards, carrots and squash.
Fruits	3 servings (½ cup each)	1 serving	2 servings of the total should be a source of Vitamin C (oranges, grapefruits, fresh tomatoes and cabbages).
Bread, Cereals Starchy vegetables	4 servings (1 slice bread or ½ cup alternates)		Use only enriched bread and cereals, rice, noodles, or spaghetti. Potatoes and corn are alternates.
Fats	3 teaspoons		May be enriched butter or margarine, oils, dressings, etc.
Additional foods	Ad lib		Desserts, sweets, other beverages, sugar, etc.

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The VD Epidemic

The AMA Council on Environmental, Occupational, and Public Health reports that venereal diseases continue to increase. Gonorrhea ranks first and syphilis third among the reportable diseases in the United States, excluding influenza.

Venereal disease is both a medical and social problem, and physicians have an important role in bringing the present epidemic under control. A combination of circumstances may be factors in the production of this epidemic. These include technical advances in contraception, changing cultural concepts and sexual mores, and much larger numbers of untreated female and male asymptomatic carriers. Frequent inadequate or inappropriate treatment of gonorrhea has led to increased resistance of the gonococcus to antibiotics.

The Center for Disease Control estimates that the reservoir of gonorrhea includes 800,000 females and about 100,000 males who are asymptomatic. To help reduce this reservoir of silent carriers, states have implemented gonorrhea screening programs for females. From July 1972 to March 1973 there were 3,117,022 females screened and 158,604 (five per cent) had a positive test for gonorrhea. Of 664,110 females tested in private physician offices, 2.5 per cent had a positive culture for gonorrhea.

During 1972, syphilis morbidity (all stages) exceeded 91,000 reported cases. Reported cases of primary and secondary syphilis numbered 24,429, up 3 per cent from the previous year, with an estimated 85,000 cases occurring annually. It is estimated that if every person in the United States could be tested for syphilis today, about a half million previously untreated cases would be found.

Nearly all states now have regulations permitting treatment of minors for venereal disease without parental consent.

Physicians in private practice treat 80 per cent of the syphilis and gonorrhea that comes to diagnosis but report to public health departments only one out of every eight cases of venereal disease that they treat. Physicians should report *all* cases of venereal disease they treat.

Neisseria gonococci have shown resistance to penicillin to the point where the recommended dosage now is 4.8 million units of aqueous procaine penicillin for gonorrhea in both males and females. Additional changes in treatment may have to be made from time to time as increasing resistance becomes a problem or more effective antibiotics are discovered.



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While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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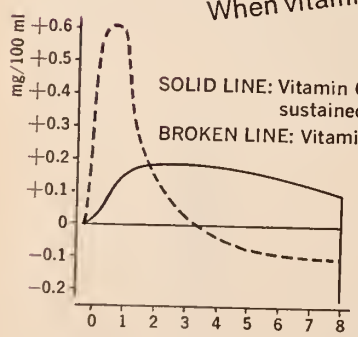


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The Doctor's Handy Guide to Chronic Child Abuse*

Phoebe Hudson, M.D./Hackensack

Over the past several years, an increasing number of battered children have been seen at our Child Evaluation Center. This is due, at least in part, to our increasing awareness of the problem, ability to look for the correct clues, and improved technics of questioning mothers. The problem is so prevalent that the approach here has become one of "suspect first and prove later." As the particular experience in this Center has increased, the dreadful realization of what has been missed, overlooked, and ignored simply because it wasn't thought of, has given us many sleepless nights. With the idea of assisting others to avoid the same pitfalls, here are clues which have been helpful in detecting the maltreated child:

Think Abuse—on *every* child but particularly those under age 3 (70 per cent are under age 3, 32 per cent under 6 months). We are speaking of the *chronic* or old problems, not the acutely injured child.

Child Observation—Any "out of line" behavior, such as:

The child doesn't cry as would be expected during your examination—as when you use the tongue depressor, or for an injection.

The child is apathetic or expressionless (not the same as a dull child).

The child is too quiet in the office. Thus, he may not be attracted to toys that should interest him. He may just sit rather than the normal investigative behavior.

The child is too active. Perhaps "flitty" type of activity may be seen. A sort of distractibility. He may slap his siblings, his mother, or just pester her. There is an abusive quality to this—it must go on constantly at home. He rarely shows fear of the parent. In fact, may repeatedly turn to her for approval or guides. May in a way "comfort" her.

Don't expect the child to answer leading questions—even if the mother is not there. He is either afraid or may feel nothing abnormal is taking place.

Negativistic behavior: He refuses to do tests or respond.

"Tuning out" behavior: He doesn't understand. Says "What" to everything you ask—almost purposefully. Yet you feel he is not really a slow child.

May act out with foster mother: Can be *very* difficult for a long time until reassured of love in spite of bad behavior. In school he may demand excessive affection and attention. He acts out.

Child's Appearance—Pale, thin, dirty. His clothes are ill fitting, don't match, are dirty. May be on a sibling the next day. Always long sleeves (to hide something). Scars are found in unlikely locations; perhaps around neck, under arm, on chest, bottom of feet, back. Many small scars may be seen anywhere (belt buckles leave an irregular deep one). Burn scars are crater shape (cigarette); loop scars suggest electric wire or coat hanger. The double edge stripe scar may mean a TV wire. Pinpoint scars may come from pins.

Mother's Appearance—She may be depressed, unkempt, or compulsively neat and clean and demand the same of children. This woman is usually so rigid she can't sit comfortably in a chair and literally speaks through clenched teeth. She blames the school for all sorts of things. She may be dressed in a sexy, immature style. She is provocative and cannot accept demands of infant—wants to be a teenager all her life. The baby annoys her. She will turn and burn the child with cigarette.

*From the Child Evaluation Center of the Hackensack Hospital. Dr. Hudson is Director of this Center.

You note little or no exchange of real feeling between parent and child. They may associate in a manner which superficially passes as normal, but on close observation, it is devoid of any palpable emotion.

She may not react to child behavior—good or bad—in the office.

She may want to talk only about her own problems and what a tough time she has. She can twist every question about the child to herself and *her* problems.

Surprisingly, often she will freely describe her abusive management of the child. Does not blame her husband or anyone else for it. But she describes her abusive behavior without much feeling.

Key Questions for the Mother—"How were you disciplined as a child?"

Nearly always in the same way. The father may say, "My father beat me (and my mother) until he broke bones and I turned out O.K." On questioning, the family history may reveal violent deaths, repeated prison records.

"How do you and your husband punish the children?"

This usually brings surprisingly frank answers. If not—

"Don't you find yourself overwhelmed with your problems at times?" "Gosh with that houseful of kids and no one around to help you, how do you keep from blowing your stack? Don't you let fly once in a while?"

"Do you and your husband get along?"

If you have established some degree of rapport (never with the rigid woman), she invariably tells you he hits her too.

Obviously, nearly all of these things are also found in normal situations, and the diagnosis of abuse has to depend on the whole picture and your judgment of it. However, the experience at the Child Evaluation Center has clearly pointed out that we have not made the diagnoses when we should have because—*we didn't want to.*

It is difficult to accept the horrors that are taking place. One tends to seek any excuse rather than face the awful realization that a mother could deliberately inflict wounds and even kill her own child. Pregnancy and having a baby do *not* confer loving and deep feelings so idealistically attributed to parenthood. You must admit this to yourself first, then, be suspicious.

You need not make a diagnosis—you must report (or be guilty of being a disorderly person, so the law reads) only on suspicion. Report to your Bureau of Children's Services. *You may save a life.*

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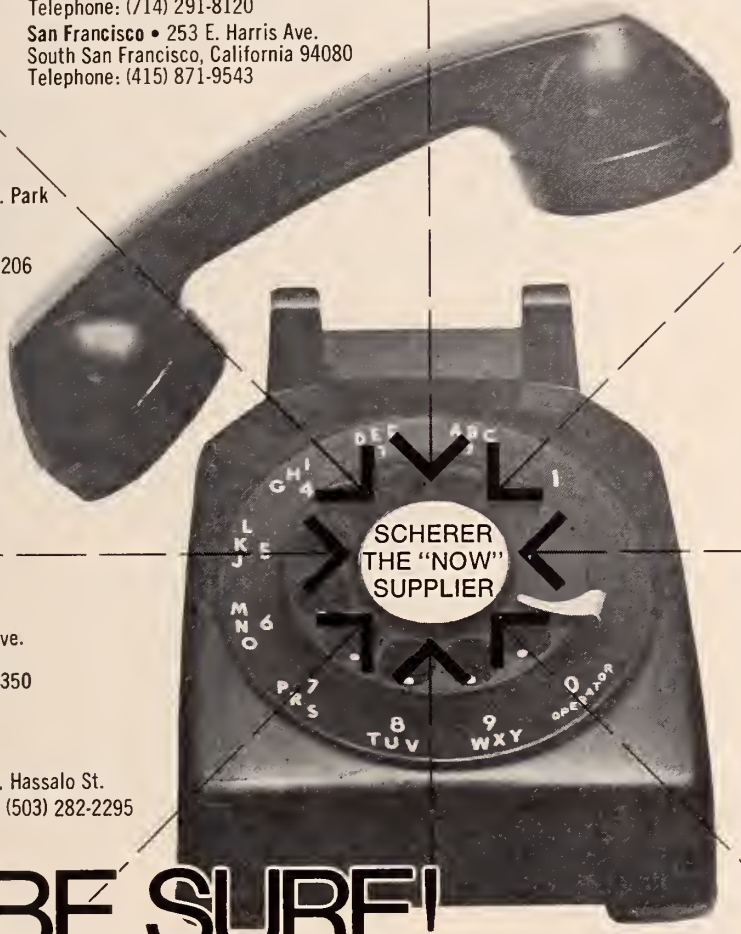
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The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows.

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Special Article

PSRO—Foundation Speaks Out on Area Designation*

The New Jersey Foundation for Health Care Evaluation was developed, not for the specific reason of meeting the challenge of P.L. 92-603 which established the controversial Professional Standards Review Organization, but to act as a forum where physicians could work with the other principals of the health delivery system—health insurers, hospital administration, and government—in an effort to solve the myriad problems that affect the physician and his patient today.

The challenge of PSRO has loomed on the horizon for the last three years, finally reaching fruition on October 30, 1972, when signed into law by President Nixon. The leadership of The Medical Society of New Jersey and the New Jersey Association of Osteopathic Physicians and Surgeons, through sponsorship of the New Jersey Foundation for Health Care Evaluation, has assumed the initiative not only for PSRO but for the whole spectrum of health care and its future delivery.

The New Jersey Foundation for Health Care Evaluation is a nonprofit corporation sponsored by The Medical Society of New Jersey and the New Jersey Association of Osteopathic Physicians and Surgeons. Incorporated on April 18, 1973, its primary goal is to ensure accessibility of quality medical care at an appropriate cost to the residents of New Jersey. Article II of our incorporation papers, entitled Purpose, #10, reads as follows: "Lessen burdens of government by the implementation of Public Law 92-603 as it relates to Professional Standards Review Organizations."

To plan for the challenges of this implementation we are united in our belief that only through physician leadership can a program be effective. We are talking about "grassroots" support of local physicians who can share not only in carrying out the program, but also in planning for its implementation. The Foundation discovered that this is the desire of practicing physicians. Our report is based on such "grassroots" opinions and recommendations concerning the first step of assigning areas in New Jersey for potential PSRO review.

Our data base consists of over 200 attendees of Regional Meetings sponsored by the Foundation in four areas in the State of New Jersey during the week of July 22. Among those represented were county medical societies, osteopathic societies, presidents of hospital staffs, chairmen of utilization review committees of hospitals, medical staffs, administrators of hospitals, the State Comprehensive Health Planning Agency, and the New Jersey Hospital Association. Approximately 80 per cent of those attending were practicing physicians.

Among the county medical societies, the majority felt that HEW's planning process (as outlined in its memo of July 6) left much to be desired, giving little time for study and interpretation of materials presented. It was also felt that the presentation of this information in such a manner is an indication that physician input is not valued and that decisions will be made regardless of our recommendations.

Inasmuch as this represents step one in the approach of HEW to PSRO implementation, one must conclude that HEW succeeded only in creating a credibility gap of real proportions. Despite the difficulties enumerated above, some positive results did emanate from the meetings held.

In all four areas one recommendation was given priority: that there should be a statewide PSRO or coordinating umbrella organization.

The recently enacted Professional Standards Review Organization law requires the Secretary of HEW to establish throughout the United States "appropriate areas" for which PSRO's would be designated. This determination must be made not later than January 1, 1974. This provision, which is set forth in Section 1152 of the Social Security Act, provides no further direction with respect to the size of the geographic areas deemed appropriate. Thus, there is no provision in the law

*Statement by R.E. Lang, M.D., President of Foundation, July 31, 1973, N. Brunswick, DHEW meeting.

which would specifically exclude an entire state as being the "appropriate area" for the formation of a PSRO. While the Senate Finance Committee Report indicates that PSRO's would include at least 300 physicians, the number must be viewed as a minimum. Moreover, it is evident from the legislative history and from the comments of HEW officials and Senate staff personnel that statewide PSRO's will be recognized in a number of states. The determination as to which states will qualify for such contracts apparently would be made on the basis of arbitrary factors in the Secretary's findings. In this respect, it should be noted that competent and willing statewide professional associations *could* be arbitrarily denied designation. There is no stated impediment in the law itself to the use of a statewide contract in all cases.

The elements for qualification as a PSRO are expressly stated in the law—a nonprofit professional association composed of licensed doctors of medicine or osteopathy, representing a substantial proportion of all such practicing physicians in the area. Membership must be voluntary and open to all such practitioners in the geographic area. There could be no requirement of membership in or payment of dues to any organized medical society or other association. The association must have professional competence to perform review services. The designation of a statewide PSRO or umbrella would not be inconsistent with any of the PSRO requirements.

It is true that the statute calls for the creation of statewide councils in states in which there are located three or more PSRO's. However, this language should not be misread to require the formation of three or more PSRO's. The provision to create the Statewide Council is intended to be operative only in those situations where the State has been so districted. The optional nature of the Statewide Council reinforces the expectation that statewide PSRO's or umbrellas would develop. This would be feasible since it:

(1) Certainly is not prohibited by P.L. 92-603.
(2) Would cost less,
(3) Would offer more assurance that PSRO will be universally established,
(4) Would offer more assurance that actual PSRO review would be initiated sooner,
(5) Would make implementation of a statewide data collection, storage, and utilization system easier,
(6) Would make implementation of a nationwide data collection, storage, and utilization system easier,
(7) Would reduce the number of contracts HEW would need to negotiate,
(8) Would reduce the number of employees HEW would need to employ as liaison personnel,
(9) Would reduce expenses because centralized administration would obviate needless duplication of effort,
(10) Would provide a backup pool of medical knowledge and review capability if local groups of physicians fail to carry out acceptable review,
(11) Would allow for prompt response to PSRO rule changes,
(12) Would build upon the administrative and appeal experience already ongoing under the sponsorship of the state medical society,
(13) Would facilitate easier interfacing with third party payers,
(14) Would be better equipped to respond to deficiencies in medical practice identified by PSRO review with proper continuing medical education programs,
(15) Would promote physician goodwill and acceptance of the program, and
(16) Would simplify the development of norms of care.

PSRO's should not cross state lines. In general, a PSRO area should not divide a county. If such a situation is contemplated, it should be made by the practicing physicians in the area in question; decisions should not be imposed without their consultation. Recommendations are as follows:

Area 1—Bergen, Hudson, Passaic, and Sussex Counties.

Based on discussions of the following indices, which included such subjects as, number of physicians—both M.D.'s and D.O.'s—number of institutions and beds, Medicaid and Medicare population, facilities available, natural geography, and proximity of travel, the following recommendation was made for their planning area:

Recommendation: That the counties of Bergen, Hudson, and Passaic each be considered a PSRO area potential in itself. (Sussex County finds that due to its medical and county character it prefers to consider consolidation with Morris and Warren Counties as one potential PSRO area.)

Area 2—Essex, Morris, Union, and Warren Counties.

Based on discussions of the following indices, which included such topics as the number of

institutions and beds, Medicaid and Medicare population, facilities available, natural geography, and proximity of travel, the following recommendation was made for their planning area:

Recommendation: That the counties of Essex and Union each be designated as a PSRO area. (Morris and Warren Counties agree that a long history of a cooperative working relationship with Sussex County could suggest that these three counties be considered a PSRO area.)

Area 3—Hunterdon, Mercer, Middlesex, Monmouth, Ocean, and Somerset Counties.

These counties presented three options, based on demographic information contained in the HEW July 6th correspondence to interested health organizations, which was distributed at the meeting. They are presented in order of priority options for their planning area.

Option One: That the six counties mentioned above be included as one potential area designation for PSRO.

Option Two: That Monmouth and Ocean Counties be considered a possible area for PSRO designation, that Somerset and Middlesex Counties be considered a possible area for PSRO designation, and that Hunterdon and Mercer Counties be considered a possible area for PSRO designation.

Option Three: That Monmouth, Ocean, and Middlesex Counties be considered a PSRO area, and that Hunterdon, Somerset, and Mercer Counties be considered a potential area for PSRO.

Area 4—Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, and Salem Counties.

Based on discussions of demographic information, as well as the medical character of this southern part of the State, the attendees of this meeting, who comprised representation of the seven counties, made the following recommendations as to their area.

1. That all seven counties agree that a PSRO for the entire area was a first choice.

2. That Camden and Burlington Counties be considered a PSRO area, and that Atlantic, Gloucester, Salem, Cumberland, and Cape May Counties be considered a second PSRO area.

This report is a fact-finding synopsis based on input from those physicians who represent their counties and hospitals, and, in some instances, represent themselves. The Foundation wishes to reflect the opinion that these recommendations also serve as our recommendations to the Department of Health, Education, and Welfare for its consideration in determining PSRO area designation for the State of New Jersey.

The following are some of our own recommendations, based on the consensus of the Foundation's Board of Trustees which deserve to be put on the table.

That for purposes of future planning in this particular area, and in other areas, physician organizations such as county societies, should be given prior opportunity to meet with representatives of HEW, to discuss plans from the beginning, rather than wait to be presented packets of information, which appear to many as foregone conclusions.

We fully realize the situation in which Region II of HEW has been placed, but we also understand that on October 30, 1972, P.L. 92-603 was signed into law by President Nixon. We are concerned that the first indication of area discussion comes as a result of a July 6, 1973 letter, to seek input from, as it is termed, interested parties. No input was asked for in the pre-planning stage; such input, we have found, certainly does exist in New Jersey.

If HEW finds the recommendations in this report unworkable, alternate suggestions should be discussed, and solutions developed with physicians, either through county societies or public meetings in the areas in question.

We would like our position to reflect that the final regulations include reimbursement of reviewing physicians by the Federal government for their activities in established PSRO's.

I must point out that the work of the Foundation needs your support. We, as practicing physicians, have developed and directed Foundation policies and will continue to do so. The results to date have been gratifying. Since many of us feel that this could be the last stand of organized medicine, our intent is to make it count.

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NEW JERSEY DOCTORS' NOTEBOOK

A Sentimental Journey

The Nevin Testimonial Dinner-Dance, held September 16, 1973, is a night to recall—full of memories, overflowing with deserved recognition, and intertwined with sobering thoughts of the future.

The many friends of Richard I. Nevin, who attended the affair, were rewarded with his touching address to the audience. We here reprint his talk for the benefit of friends and associates who were unable to be present. Although the oration will be lacking, dedication of a man among men will be more than evident.

"This gentle and unforc'd accord sits smiling to my heart."

It is said that at the moment of death all of one's life passes before him in critical review. I cannot vouch for the accuracy of that allegation, but I can assure you that, at a time and under circumstances such as you have magnanimously created for me tonight, one's life does pass in review. I have looked over the chronicle of my years and found it good—largely because it was my happy fortune to be in gratifying and rewarding association with good and generous people such as you. To all who have been, intimately or casually, a part of the pleasant fabric of my life—to my dear wife and my beloved family, to teachers, relatives, students, friends, and acquaintances—I offer, from a brimming and happy heart, sincere and everlasting thanks for all that they have given me.

Every life holds high-lights of experience which because of their soul-enriching significance are a delight to remember. For me this evening is such an experience . . . a "crystal moment of September"—which you and I share together. Robert P. Tristram Coffin has written of a crystal moment in his life. Permit me to quote his lines to you, as having application to the circumstances of our gathering here tonight . . .

Once or twice this side of death
Things can make one hold his breath.

From my childhood I remember
A crystal moment of September.

A wooded island rang with sounds
Of church bells in the throats of hounds.

A buck leaped out and took the tide
With jewels flowing past each side.

With his high head like a tree
He swam within a yard of me.

I saw the golden drop of light
In his eyes turned dark with fright.

I saw the forest's holiness
On him like a fierce caress.

Fear made him lovely past belief;
My heart was trembling like a leaf.

He leaned towards the land and life
With need above him like a knife.

In his wake the hot hounds churned;
They stretched their muzzles out and yearned.

They cried no more, but swam and throbbed;
Hunger drove them till they sobbed.

Pursued, pursuers reached the shore
And vanished. I saw nothing more.

So they passed, a pageant such
As only gods could witness much.

Life and death upon one tether
And running beautiful together.

Early in life I realized the intimate and inseparable relationship between life and death. I recognized that in our human span, like joys and sorrows, hopes and fears, life and death go hand in hand. One is as much part of the other as the convexity and concavity of a curve. Nor does death have the power to terminate the interpersonal bonds which life has forged, for love endures and bridges the barricades of death. Oblivion is the lot only of those unfortunates who are neither loved nor remembered.

I rejoice in the presence of all of you who are here tonight, but I am equally exultant in the

consciousness of the spectral presence here also of those myriad persons who are bound to me by ties of mutual esteem and affection. Members of my family, teachers who inspired and guided me, boys whom I taught, physicians with whom I served the interests of the medical profession and our beloved Society . . . all, I sense, are looking down over the ramparts of heaven and are in spirit joining in our gala gathering here tonight. "Life and death upon one tether, running beautiful together."

Many years ago, about the time when "I was one and twenty," I read Woodrow Wilson's "Address at Swarthmore College." In it he says:

"No one can stand in the presence of a gathering like this, on a day suggesting the memories which this day suggests, without asking himself what a college is for. There have been times when I have suspected that certain undergraduates did not know. I remember that in days of discouragement as a teacher I gratefully recalled the sympathy of a friend of mine in the Yale faculty who said that after twenty years of teaching he had come to the conclusion that the human mind had infinite resources for resisting the introduction of knowledge. Yet I have my serious doubts as to whether the main object of a college is the introduction of knowledge. It may be the transmission of knowledge through the human system, but not much of it sticks. Its introduction is temporary; it is for the discipline of the hour. Most of what a man learns in college he assiduously forgets afterwards. Not because he purposes to forget it, but because the crowding events of the days that follow seem somehow to eliminate it.

"What a man ought never to forget with regard to a college is that it is a nursery of principle and of honor. I cannot help thinking of William Penn as a sort of spiritual knight who went out upon his adventures to carry the torch that had been put in his hands, so that other men might have the path illuminated for them which led to justice and to liberty. I cannot admit that a man establishes his right to call himself a college graduate by showing me his diploma. The only way he can prove it is by showing that his eyes are lifted to some horizon which other men less instructed than he have not been privileged to see. Unless he carries freight of the spirit he has not been bred where spirits are bred."

These concepts I urged upon my students in my teaching days. These concepts I also urged upon the members of The Medical Society of New Jersey. They were never more pertinent than now in these times of spiritual malnutrition and of moral decline. If you of the profession of medicine are successfully and worthily to fulfill yourselves and your potentialities for sound leadership, if you are effectively to minister to the essential health of people and of human society, if you are seriously bent upon improving the "image of the doctor" then, I beg of you, in all that you do, to demonstrate clearly that you carry "freight of the spirit" and to show that your eyes—and your hearts—are lifted to the horizons of vision and of worth that enable and sustain, with dignity and distinction, all the actions of human life.

For all that you have given me and mine, and for all that you have meant and mean to me in terms of friendship and of love, I thank you. Whether the years left to me are many or few, I shall never forget you. Happily, Shakespeare has supplied, most beautifully and faithfully, the fervent assurances concerning your place in my future which I give you now:

When to the sessions of sweet silent thought
I summon up remembrance of things past,
I sigh the lack of many a thing I sought,
And with old woes new wail my dear time's waste:
Then can I drown an eye, unused to flow,
For precious friends hid in death's dateless night,
And weep a fresh love's long since canceled woe,
And moan the expense of many a vanished sight:
Then can I grieve at grievances forgone,
And heavily from woe to woe tell o'er
The sad account of fore-bemoaned moan,
Which I new pay as if not paid before.
But if the while I think on thee, dear friends,
All losses are restored and sorrow ends.

. . . God keep you, all!

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Therapeutic Drug Information Center

The New Jersey Regional Pharmaceutic and Therapeutic Drug Information Center, located at the Valley Hospital, Ridgewood, New Jersey, serves as a source of information on specific problems, articles, and reports concerning pharmaceutic and therapeutic information. A specialized library maintained by the Center contains complete information about U.S., foreign, investigational, and proprietary drugs, including their identification, availability, interactions, compatibility, side effects, dosage, adverse reactions, and so on.

The Center is staffed by trained pharmacists. Jack M. Rosenberg, Pharm. D., Associate Professor of Pharmacy and Director of Drug Information, Brooklyn College of Pharmacy, LIU, serves as Consultant Director. Salvatore Peritore, M.S., serves as Project Director, and Kenneth Anderson, Assistant Project Director. The service is provided free, open seven days a week, and is available by telephone—(201) 445-4900, extension 304. To date, over 2,000 questions have been received by the Center, the majority from physicians. Below are three questions and answers handled by the Center recently.

1. Is there an association between narcotic addiction and false positive VDRL?

Narcotic addicts exhibit a high percentage of false positive reactions to a number of non-specific serologic tests for syphilis, among which is the VDRL. Two procedures that are specific for treponemal antibodies —the treponema pallidum immobilization (TPI) test, and the fluorescent treponemal antibody (FTA) test —are unaffected by narcotic addiction and provide a better indication of syphilis in these patient.[1]

Harris, *et al.*,[2] studied the sera of 665 imprisoned narcotic addicts and found a false positive rate of approximately 50 per cent comparing nonspecific serologic test results with specific treponemal tests.

Boak, *et al.*,[3] reported that the sera from 163 of 172 narcotic addicts who yielded a positive reaction to a serologic test for syphilis were non-reactive in TPI tests. She concluded that a diagnosis of syphilis should not be made on a drug addict with a positive serologic test for syphilis without verification with a TPI test.

Sapira[4] reported a false positive rate of approximately 74 per cent in a group of 75 narcotic addicts when positive reacting VDRL results were compared by TPI test results.

In another report[5] a 58 per cent incidence of false positivity was found in a group of female addicts arrested on prostitution charges when VDRL results were compared to TPI tests.

False positive VDRL reactions have persisted in ex-addicts after 14 months' abstinance from opiates.[6]

The incidence of false positive results in nonspecific serological tests for syphilis (from 50 to 95 per cent) in narcotic addicts makes the confirmation of such finding via TPI or FTA tests absolutely mandatory before a diagnosis of syphilis can be made in a narcotic addict.

References

[1]Hirschman, J. L. and Troutman, W. G.: *Drug Intelligence and Clinical Pharmacy,* 6:21 (January 1972)

[2]Harris, A., *et al.: Public Health Report,* 77:537 (June 1962)

[3]Boak, Ruth A., *et al.: JAMA,* 175:138 (1961)

[4]Sapira, Joseph D.: *American Journal of Medicine,* 45: 555 (1968)

[5]Harris, W. D. and Andrei, J.: *New York Journal of Medicine,* 67:2967 (1967)

[6]Tuffanelli, D. L. and Wuepper, K.D.: *Clinical Research,* 15:255 (1967)

2. What is the dose of penicillin to be used as a skin test for "penicillin allergy"?

Penicillin allergy is a very common hypersensitivity reaction and can be expected to occur in 1 to 3 per cent of patients tested.

There are a number of commercially available scratch tests to aid in the identification of patients who may be "allergic" to penicillin.

If a patient has a history suggestive of allergy, penicillin should not be given if another antibiotic is equally suitable for treatment. On the other hand, if penicillin is specifically required, preliminary skin tests with small doses (100 units or μg.) of penicillin G or the appropriate derivative, and with penicilloyl polylysine if available, will detect true hypersensitivity in about 50 per cent of cases. In these cases penicillins should either be avoided or used with great caution. In the remainder, penicillins can be given in incremental doses, starting with 1000 units or the equivalent weight. In all such situations, including skin tests, resuscitative measures (i.e., oxygen and a syringe loaded with epinephrine) should be at hand. In some instances, reactions can be "smothered" with antihistamines sufficiently for completion of a course of treatment.

Note: Penicilloyl is an investigational drug product and at present its use is restricted to approved clinical investigators.

Reference:

Kagan, Benjamin: *Antimicrobial Therapy,* Philadelphia, Saunders, 1970, p. 24

3. Are there any reports of organic brain syndrome resulting from the concomitant use of phenothiazines and agents for Parkinsonism?

Phenothiazines, tricyclic anti-depressants, and agents for Parkinsonism (Parasympatholytic agents) given alone or in combination can cause a toxic confusional state known as "central anti-cholinergic syndrome".[1]

This syndrome is characterized by disorientation, lack of attention, agitation, visual and auditory hallucinations, anxiety, insomnia, illusions, loss of short-term memory, purposeless movements, pantomine activity with nonexistent objects, and agitation characteristic of an organic brain syndrome.

The signs of parasympathetic blockade include widely dilated unreactive pupils, "atropine flush," dry parched mouth, foul breath, dysphagia, elevated temperature, blurred vision and photophobia, a rash on the face, neck, and upper trunk, urinary urgency and difficulty in urination, muscular incoordination, and tachycardia. The behavior and mental symptoms may suggest an acute organic psychosis.[2, 3]

The physiologic basis of central anti-cholinergic syndrome is the competitive inhibition by atropine-like compounds. The phenothiazines, tricyclic anti-depressants and drugs for Parkinsonism all have some atropine-like side effects and together have additive effects.

The treatment of anti-cholinergic syndrome includes reduction of the dose of the causative agent and treatment with physostigmine salicylate, a direct antidote to the atropine effects, both peripheral and central.[3]

Duvoisin, *et al.*[4] found doses of 1 to 2 mg. parenterally to be an effective antidote to intoxication with centrally active anticholinergic agents.

Heiser and Gillin[2] recommend an initial dose of 2 mg. physostigmine salicylate administered IM or IV for a normal-sized adult. If no improvement is seen in 15 minutes, a second 1 to 2 mg. dose may be given.

El-Yousef, *et al.*[1] recommend the use of a 1 mg. IM test dose of physostigmine followed 20 minutes later by an additional dose of 2 to 3 mg. Alternatively the salicylate may be administered every 20 minutes in 1 mg. doses until symptoms are alleviated or until 4 mg. have been administered.

Since physostigmine is rapidly destroyed in the body (1 to 2 hours), repeated injections are sometimes necessary if the physostigmine effects decrease before the anti-cholinergic effects have ceased.

Because of the possibility of hypersensitivity in an occasional patient, atropine sulfate injection should always be at hand since it is an antagonist and antidote for physostigmine.[5]

References

[1] El Yousef, M.K., *et al: Am. J. Psychiatry,* 130:141 (February 1973)

[2] Heiser, J.F. and Gillin, J.C.: *Amer. J. Psychiatry,* 127:1050 (February 1971)

[3] Goodman and Gilman (editors: *The Pharmacological Basis of Therapeutics,* ed. 4. New York, MacMillan, 1970, pp. 534-535.

[4] Duvoisin, Roger C. and Koty, R.: *JAMA,* 206:1963 (1968)

[5] Package Insert, *Antilirium Ampule* (Physostigmine Salicylate) O'Neal, Jones, and Feldman, Inc., St. Louis, Missouri

Communicable Diseases in New Jersey

The following communicable diseases were reported to the Division of Laboratories and Epidemiology during September 1972:

	1973 September	1972 September
Aseptic Meningitis	67	83
Primary Encephalitis	7	3
Hepatitis: Total	185	262
Infectious	98	212
Serum	37	50
Unspecified	50	0
Malaria: Total	1	1
Military	1	0
Civilian	0	1
Meningococcal Meningitis	3	0
Civilian	3	0
Mumps	17	13
German Measles	9	1
Measles	23	3
Salmonella	104	135
Shigella	75	28

Shigellosis

Shigellosis has long been a problem in institutions throughout the country. There were three significant outbreaks in New Jersey this summer.

Shigella flexneri, 2a, broke out among patients and staff at a residential home for retarded and multiple handicapped children. The index case was a nine-year-old ambulatory female patient who became ill on July 13. Over the next three weeks 18 of 147 (12 per cent) had positive cultures with the highest attack rates among ambulatory male and female patients, 46 per cent (6 of 73) and 33 per cent, (5 of 15) respectively. The children with positive cultures were not usually clinically ill while all employees (5 of 71) with positive cultures had clinical manifestations. Organisms isolated were *S. flexneri* 2a, with two exceptions—one type 3 was identified and a *Shigella sonnei* was cultured from a resident. Control measures were instituted and the epidemic ended during the first week in August.

The second institution was a State school which provides residential care for retarded children. On August 22, there was an outbreak of diarrheal illness associated with positive stool cultures for *S. flexneri,* Type III,

involving two of nineteen residential cottages, one with a 26 per cent attack rate (13 of 50) and one with a 4 per cent attack rate (2 of 50). The only culture-positive staff member worked in a non-ambulatory, completely autonomous cottage, and the employee is the presumed source of the epidemic.

The third outbreak occurred in a private camp, a non-profit residential summer camp for handicapped and crippled children. Diarrheal illness started on August 19, 1973, involving 16 patients—12 of 26 children (46 per cent) and 4 of 25 staff (16 per cent). Thirteen of the sixteen patients were males (81 per cent), presumably related to the common male toilet facilities. The disease was clinically mild and self-limited. Of the twelve patient stools examined, six revealed *Shigella sonnei*, resistant to ampicillin. The epidemic was terminated by closing the camp.

There is growing concern about the emergence of resistant strains of *Shigella* related to the indiscriminant use of antibiotics. Accordingly, specific antibiotic treatment, while indicated for symptomatic cases (because it shortens the duration of clinical illness and decreases time of shedding of organisms) should not be administered categorically for asymptomatic carriers.

208th Annual Meeting
May 11-14, 1974
Chalfonte-Haddon Hall
Atlantic City
Scientific Exhibit Applications
Now Being Reviewed
(See page 875 this issue)

Patient Education

The following is a policy statement approved by the Steering Committee of the CMDNJ—Rutgers Medical School Program in Consumer Health Education, July 24, 1973.

1. Patient education, far from being the option it was considered in the past, has become a necessity for the effective management of most patients, especially pediatric and OB patients, those with chronic illness, permanent disability, drug, alcohol or other addiction, and significant psychosomatic complications.

2. While a great deal of effective patient education can and should be carried out by individual doctors, nurses, and other professionals, the total need and demand can be met only through coordinated input from all the relevant health professions. This calls for multi-disciplined teams, whose membership will vary according to the illness category, socioeconomic background of the patient, and other factors.

3. While patient education can and should take place whenever and wherever there are encounters between health professionals and patients, the most appropriate sites for the establishment and funding of multi-disciplined teams and for the coordination of health education programs are the community hospital and/or community health centers.

4. In the case of hospitalized patients, their education should start with admission—even pre-admission in situations where pre-admission testing is in effect—and continue at appropriate points throughout the hospital stay. In the case of surgical patients special attention should be given to the patient's understanding of the surgical procedure as well as pre- and post-operative procedures. Discharge planning and preparation for home care provide a particularly good opportunity for education of the patient with chronic illness or residual disability.

5. The goal of the Rutgers Program in Consumer Health Education is not to promote the employment of health educators as such. The

primary aim is to stimulate the existing professions and institutions to undertake this essential activity insofar as possible with existing resources. Experience indicates, however, the desirability of establishing a visible office of community health education within the hospital or health center, with a formally designated director or coordinator, an advisory committee, and a separate budget. The coordinator could be a physician, a nurse, a social worker, or an educator. Some training or experience in educational or communications' techniques, especially audio-visual techniques, is desirable.

6. The cost of patient education will vary from institution to institution, depending upon the nature of the program, size of hospital, type of staffing, availability of professional and community resources, and so on. A modest but practical approach suggests a first-year budget of $100 per bed, e.g. $25,000 for a 250-bed hospital. This would include $10,000 to $16,000 for a director or coordinator, a part-time secretary, instructors, and teaching and promotional materials. It assumes that space, office equipment, and audio-visual hardware are provided by the hospital outside this budget.

7. Development funds may be available from a variety of sources, including the federal and state governments, private foundations and health agencies, and the drug industry. On the other hand, long-term financing will require different approaches. Every effort should be made to make individual programs as nearly self-supporting as possible. Modest registration fees, waived in the case of financial hardship, are feasible and usually not resented.

Such a program cannot be supported entirely by patient or student fees, however. It is very much to be hoped that hospital-based patient and community health education will soon be considered allowable expenses for third party reimbursement. The Department of Health, Education, and Welfare is apparently moving in this direction with respect to Medicare and Medicaid. It is our hope that New Jersey Blue Cross and the New Jersey Department of Insurance will also move in this direction.*

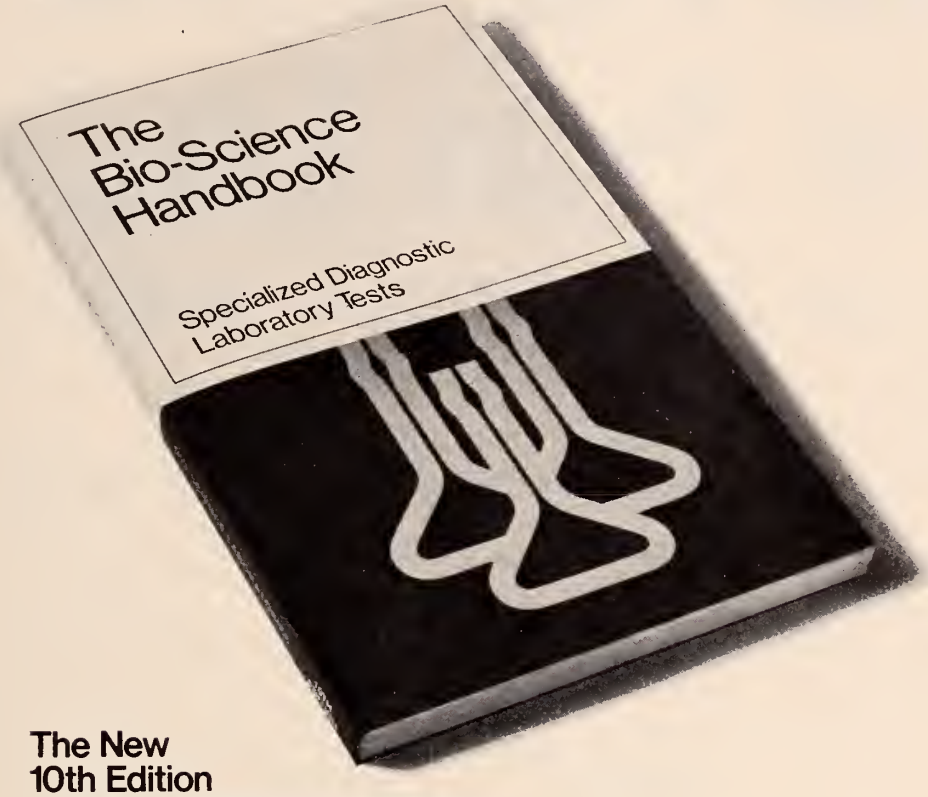
8. A corollary of such third-party reimbursement is the requirement for more rigorous criteria for approval and evaluation of performance than was generally true of health education programs in the past. A primary objective of the Rutgers program is to help in the development of such criteria and evaluation techniques and to provide teaching materials and technical assistance to interested hospitals and health centers, when requested. The School will also help to obtain start-up money from appropriate sources, and a few demonstration projects will be funded directly as the budget permits.

*Since this statement was written, the Advisory Committee to the New Jersey Commissioner of Insurance recommended inclusion of patient education expenses as an allowable "element of cost" for third-party hospital reimbursement and the Department of Insurance has approved such inclusion, subject to the usual tests of reasonableness that apply to all elements of cost. The first such requests by individual hospitals will probably be made in 1974.

CLINICAL NOTES

Readers of THE JOURNAL are invited to submit personal contributions for this new page. Material of general interest, which can be concisely summarized (one or two paragraphs—up to 150 words), and does not require a thorough report, is preferred. If you have a successful new procedure, a brief practical suggestion, or a bizarre or unusual clinical experience you would like to share with your colleagues, please send it to us (PO Box 904, Trenton 08605) for "Clinical Notes."

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CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President, CMDNJ

On September 26, Governor William T. Cahill directed the College of Medicine and Dentistry of New Jersey to move ahead with plans for a third medical school to be located in South Jersey. The new program for medical education in the southern section of our state is to be based on the concept of a "medical school without walls."

Governor Cahill's directive was based on months of careful study by members of the College staff who met personally not only with our colleagues in the medical and dental professions but also with health care delivery executives and civic leaders. This is not a mandate to build another physical plant similar to the ones being constructed in Newark and Piscataway areas. It clearly directs the College to move toward the establishment of this third medical education program without making major capital expenditures for new buildings.

Present plans suggest that the South Jersey medical education program use the existing facilities in Piscataway and Newark for the first two years of basic science instruction. As planned, the last two years of clinical training would take place in strong community hospitals in South Jersey. Local, community-based physicians would serve as a portion of the faculty.

The "school without walls" would help alleviate the shortage of physicians in South Jersey and would dramatically improve the accessibility of health care delivery in that area of the state. Research has demonstrated that there is a strong need for a program of medical education in South Jersey. It is estimated that South Jersey will need a net addition of approximately 100 physicians a year to keep up with the anticipated demand for medical services and the natural attrition. Until now that area has had to depend, to a very large extent, upon attracting foreign physicians and physicians from other states to meet this demand for medical services, and no one can predict the stability of immigrating physicians either from other states or foreign countries in the near future.

Another critical area of concern is that less than 20 per cent of internship and residency positions offered by South Jersey hospitals are filled with graduates of American medical schools. The remainder are either unfilled or filled with graduates of foreign medical schools. The South Jersey medical education program would help attract more interns and residents, many of whom may decide to practice near the hospitals where they received their training.

New Jersey residents are finding that the number of places once open to them in Philadelphia medical schools has been reduced. They are also finding that other states are extremely reluctant to take New Jersey medical school applicants.

For all these reasons, a medical education program is urgently needed to provide a stable base for growth of physician manpower in South Jersey. The nontraditional concept of a "medical school without walls" would provide other important advantages. It would assure maximum benefit for a minimum input of tax dollars. This type of school can be developed much more quickly than if the State were to build another traditional medical school with a basic science building and a teaching hospital. The concept also provides a greater emphasis on primary patient care as an important community benefit.

The development of a unique third medical education program offers New Jersey the opportunity to become a pace-setter in the field of medical education.

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Pharmaceutical News

Prepared by the New Jersey Regional Pharmaceutic and Therapeutic Drug Information Center, through the Valley Hospital, Ridgewood, New Jersey, and Brookdale Inter-regional Pharmaceutic and Therapeutic Drug Information Center at Brooklyn College of Pharmacy, Long Island University.

Large Burns in Humans—Treatment With Heparin. Saliba, Michael J., Dempsey, William C., and Kruggel, John L.
JAMA, 225:261-269

Seven patients with deep second and third degree burns covering from 15 to 60 per cent of their bodies were treated with large doses of heparin sodium administered parenterally and topically. Heparin relieved the pain and prevented burn extension. No edema, symptoms of toxic reactions, or shock developed. Fluid therapy requirements were significantly less. There was enhanced revascularization, granulation, and re-epithelialization without contracture, infection, or graft. Reprint address: M. J. Saliba, M.D., 3737 Moraga Ave., San Diego, California 92117.

The Effect of Sodium Dextrothyroxine on Serum Cholesterol and Mortality Rates in Cardiac Patients. Bernstein, A., Simon, F., Schmitz, T.H., and Warner, W.L.
Angiology, 24:205-211

A nine-year retrospective study indicated that sodium dextrothyroxine (Choloxin®) was perfectly satisfactory as a substitute for diet when, for whatever reason, diet is ineffective as lipid-lowering therapy. The survival rate for dextrothyroxine-treated patients was comparable to those of diet-treated patients, and markedly greater than groups receiving no hypocholesterolemic therapy. Reprint address: Arthur Bernstein, M.D., 2130 Millburn Ave., Maplewood, New Jersey 07040.

Inorganic Phosphate Treatment of Nephrolithiasis. Ettinger, B. and Kolb, F. O.
American Journal of Medicine, 55:pp. 32-37

Results of long-term oral inorganic phosphate therapy in 47 patients (45 with hypercalciuria before treatment), suffering from recurrent calcium-containing urinary calculi, indicated that phosphate therapy had no effect on urinary calcium excretion or stone passage but did appear to reduce significantly the need for lithotomy. The stone passage-removal rate in the 5 years before therapy was significantly greater than during the years of treatment. Patients who were free of stones at the start fared best. Reprint address: F. O. Kolb, M.D., Metabolic Research Unit, 1143-HSW, University of California, San Francisco, California 94122.

Effect of Drug Treatment for Lymphoma on Male Reproductive Capacity: Studies of Men in Remission after Therapy. Sherins, R. J. and DeVita, Jr., V.T.
Annals of Internal Medicine, 79:216-220

Reproductive function was evaluated in 16 men, in remission, who had been treated with a combination of chemotherapeutic agents for lymphoma, and had received no therapy for six months to seven years. Although libido and potency were normal in all patients, ten were azoospermic; two showed minimal evidence of spermatogenesis; and four, in remission for two to seven years, showed complete spermatogenesis. These data suggest that spermatogenesis may return after extensive chemotherapy but that this is more likely to occur more than two years after drug treatment. Reprint address: Richard J. Sherins, M.D., Bldg. 10, Room 12N208, National Institute of Health, Bethesda, Maryland 20014.

VA Medical Care Extended

Legislation signed into law extends Veterans Administration medical care to certain dependents, assures peacetime veterans the right to VA medical care, and streamlines VA rules on health care delivery. Outpatient medical care for non-service connected conditions is authorized when it would avoid the need for hospitalization.

The law which was effective September 1, extends eligibility for medical care to the wife or child of a person who has a total and permanent disability resulting from a service-connected condition, and to the widow or child of a person who has died of a service-connected condition. Care will be provided in a manner similar to that in which medical care is furnished by the Armed Forces under the so-called "CHAMPUS program" to dependents and survivors of active duty and retired personnel. The requirement for wartime service as a condition of eligibility for VA medical care has been removed.

The law also authorizes direct admission to nursing homes, at VA expense, of veterans requiring nursing home care for service-connected disabilities as stated by a VA physician, authorizes VA outpatient care for all disabilities for veterans with service-connected disabilities rated 80 per cent or more disabling, provides for the National Academy of Sciences to study the staffing of the VA hospitals and report on this subject, and extends VA mental health service to the families of veterans when it is related to the mental health or rehabilitation of an eligible veteran.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

ANESTHESIOLOGY— George D. Tedesco, M.D., 801 Inverness Avenue, Apt. B-13, Nashville, Tennessee 37204. Buenos Aires 1970. Group. Available July 1974.

GASTROENTEROLOGY— Robert A. Pastore, M.D., 12262 East Arizona Drive, Aurora, Colorado 80012. Georgetown 1964. Board certified. Group or hospital. Available July 1974.

GENERAL PRACTICE— Suresh C. Doshi, M.D., 104-2A Oakville Drive, Pittsburgh, Pennsylvania 15220. University of Bombay 1961. Group, partnership, or house physician. Available.

INTERNAL MEDICINE— Ernest T. Bajpai, M.D., 111 East Mont Lane, Sicklerville 08081. Prince of Wales (India) 1955. Board eligible. Corporation, group, or partnership. Available July 1974.

Robert I. Birns, M.D., 2185 Lemoine Avenue, Fort Lee 07024. Washington University (St. Louis) 1970. Board eligible. Subspecialty, pulmonary medicine. Hospital, group, partnership, or solo. Available July 1974.

Kumar Ram Mohan, M.D., 264-08 Langston Avenue, Glen Oaks, New York 11004. Medical College, University of Madras (India) 1968. Board certified. Subspecialty, gastroenterology. Group, associate, or partnership. Available July 1974.

Austin M. Pattner, M.D., 5960 Culzean Drive, Dayton, Ohio 45426. SUNY (Syracuse) 1966. Board eligible. Subspecialty, nephrology. Group or partnership. Available September 1974.

Romulo J. Mora, M.D., 1512 Greenbrier Drive, Huntington, West Virginia 25704. Santo Tomas (Philippines) 1961. Board eligible. Partnership or solo. Available.

David A. Ingis, M.D., 2411 Woodmere Drive, Cleveland, Ohio 44118. NYU 1968. Board certified (IM), Board eligible (GE). Group or partnership. Available.

OBSTETRICS-GYNECOLOGY— Vasant V. Dalal, M.D., 10 Lamont Avenue, Apt. 11, Trenton 08619. King Edward Memorial Hospital (Bombay) 1962. Group, associate, or house physician. Available January 1974 —as house or institutional physician available now.

Bohdan Malyk, M.D., 1106 Winding Road, Dover, Delaware 19901. Jefferson 1968. Board eligible. Group or partnership. Available September 1974.

Dhan K. Chettri, M.D., 39 Wendover Road, Rochester, New York 14610. Calcutta Medical 1958. Board eligible. Group, partnership, or solo. Available.

ORTHOPEDICS— Edmund R. Kappy, M.D., 231 Palisade Road, Elizabeth 07208. New York Medical 1967. Board eligible. Group, associate, or partnership. Available.

PATHOLOGY— Khwaja A. Siddiqui, M.D., 454 Garden Boulevard, Garden City, New York 11530. Kabul University (Afghanistan) 1962. Board eligible. Group, partnership, solo. Available.

Yadoolah Gorji, M.D., 3455 Street Road, Wither-Spoon #8, Cornwells Heights, Pennsylvania 19020. Tehran 1964. Board eligible. Hospital practice. Available August 1974.

PEDIATRICS—Stephen King, M.D., 3417 High Street, Dover, Delaware 19901. SUNY (Downstate) 1969. Group or partnership. Available September 1974.

Wen-Hsiung Lu, M.D., 3015 Tall Pine Lane #6, Jacksonville, Florida 32211. National Taiwan University 1963. Board eligible. Subspecialty, pediatric nephrology. Group or partnership. Available January 1974.

B. S. Paraswanath, M.D., 1005—18th Avenue, North, Nashville, Tennessee 37208. Mysore Medical College 1965 (India) Board certified. Subspecialty, neo-natology. Group or partnership, institutional or clinic. Available January 1974.

Hing-Ling Taang, M.D., One Bogardus Place, Apt. 2-N, New York 10040. Wuhan Medical College (China) 1960. Board eligible. Group, partnership, or pharmaceutical company. Available July 1974.

PSYCHIATRY—Charles D. Semel, M.D., 6303 Willowood Lane, Alexandria, Virginia 22310. Cornell 1968. Partnership, group, or solo. Available July 1974.

RADIOLOGY—Richard J. Rizzuti, M.D., 4774 West Braddock Road, Alexandria, Virginia 22311, SUNY (Downstate) 1968. Board certified. Group or partnership. Available July 1974.

SURGERY—Chong Wook Lee, M.D., 1945-20A Eastchester Road, Bronx, New York 10461. Yonsei Medical College, Seoul (Korea) 1963. Board eligible. Subspecialty, cardiothoracic surgery. Group, partnership, or solo. Available July 1974.

Arindam Purkayastha, M.D., Box 554, Johnson City, New York 13790. University of Calcutta (India) 1963. Board eligible. Group, partnership, or solo. Available.

Peter A. Haas, M.D., 2098 Butler Pike, Plymouth Meeting, Pennsylvania 19462. Budapest 1950. Board eligible. Group, partnership, solo. Available.

UROLOGY—David J. Samara, M.D., 851 East Homestead Village, Rochester, Minnesota 55901. American University of Beirut 1969. Board Eligible. Group or partnership. Available July 1974.

Mohammad N. Jam, M.D., 2905 North Charles Street, Apt. 105. Baltimore, Maryland 21218. Tehran 1964. Board eligible. Group or partnership. Available.

Mahamed F. Abidin, M.D., 245 Ogden Avenue, Jersey City 07307. Damascus (Syria) 1964. Board eligible. Group, partnership, solo. Available.

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*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D. Oouble-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964

OWNERSHIP STATEMENT

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(Act of August 12, 1970: Section 3685, Title 39, United States Code)

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R. H. Lambert, Business and Financial Manager
The Medical Society of New Jersey

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A. Total No. copies printed (Net Press Run)	9,068	9,050
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1. Sales through dealers and carriers, street vendors and counter sales	—	—
2. Mail Subscriptions	8,622	8,634
C. Total Paid Circulation	8,622	8,634
D. Free Distribution by mail carrier or other means		
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2. Copies distributed to news agents, but not sold	—	—
E. Total Distribution (Sum of C and D)	8,953	8,965
F. Office use, left-over, unaccounted, spoiled after printing	115	85
G. Total (sum of E & F—should equal net press run shown in A)	9,068	9,050

R. H. Lambert, Business and Financial Manager
The Medical Society of New Jersey

*Deceased

The Scientific Exhibits — — 208th Annual Meeting

The following information is pertinent to the scientific exhibit display at the 208th Annual Meeting of this Society, May 11 to 14, 1974. Those interested in participating may use the application form on page 875. (Please complete both sides.) Remove the page from *The Journal* and mail directly to John J. Thompson, M.D., Chairman, Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605.

Policy—It is the policy of the Committee on Scientific Exhibits of The Medical Society of New Jersey, in instances where a pharmaceutical company has aided in the production of an exhibit—either through financing or supplying products—that the name of the product or company is not to appear on any placards pertaining to the exhibit or on booth signs shown within the area of the exhibit, nor is it to appear in the description of the exhibit published in the program. However, the committee does not object to reprints of articles pertaining to the exhibit being distributed from the scientific exhibit booth. Scientific exhibitors are free to discuss with visitors to their booths products used in their presentations.

Space assigned will be a drapery booth consisting of a backwall and two sidewalls. Each booth is 6 feet deep. The backwall will vary according to the requirements of the exhibitor, and the measurement must be noted on the application. A shelf one foot wide is provided with each booth. The height of the wall above the shelf is 5 feet, 6 inches. However, the shelf will be removed if advance request is made. By eliminating the shelf, the booth will measure 8 feet in height.

Please indicate on the application if the exhibit is free-standing. Such an exhibit will not require a drapery booth.

Please indicate on the application if a sign is incorporated with your exhibit. If so, one will *not* be ordered.

If at all possible, a photograph of the exhibit should accompany the application. If a photograph is not available, a drawing will suffice.

Application for space in the Scientific Exhibit must be submitted no later than January 1, 1974, for consideration by the committee. Applications will be acted upon by the committee as soon after that date as possible and notification sent to all exhibitors. Send *completed* application, together with photograph or drawing of exhibit, to John J. Thompson, M.D., Chairman, Committee on Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton 08605.

1. *Time:* The exhibits will open officially at 12 noon, Saturday, May 11, and close at 5 p.m., Monday, May 13. On the intervening day the hours are 9 a.m. to 5. p.m.

2. *Installation and Dismantling:* Installation of exhibits may begin at 3 p.m., Friday, May 10, and all exhibits must be in place by 11 a.m., Saturday, May 11. Exhibits must remain intact until 5 p.m., Monday, May 13, and should be removed from the exhibit hall not later than 12 noon, Tuesday, May 14.

3. *Cost:* The Society provides free of charge such space exhibitor may require including booth with shelf, printed sign (*if requested*), and lights for illumination. The exhibitor must pay the cost of installing the exhibit, of renting tables and chairs, and for alterations and special construction, *including electrical connections.*

4. *Sponsorship:* All exhibits must be shown in the name of individual persons. The name of the institution may appear as part of the address. Medical schools, hospitals, clinics, and other institutions and organizations should not present exhibits in their own names, but rather in the names of the individuals who worked up the exhibit.

5. *Use of Space:* No exhibit shall interfere with another exhibit. No part of the exhibit will be allowed to extend above the top of the booth.

6. *Aisles:* Aisles must be kept clear; to this end exhibits must be so arranged that they will be inside the booth space.

7. *Advertising:* No advertising matter of any description may be distributed, nor any material shown which in any way serves for commercial propaganda.

8. *Demonstrations:* All exhibits must be in charge of competent, well-informed demonstrators. The worker who did the actual work shown, or someone who is familiar with all details, must be present at all times during exhibit hours.

9. *Motion Pictures:* Motion pictures may be shown in booths. Films are subject to preview at the discretion of the committee. They shall be non-inflammable, and *silent.* The exhibitor must supply his own screen, projector, and operator.

10. *Liability:* It is agreed that exhibitors shall indemnify and hold blameless The Medical Society of New Jersey and Haddon Hall from all liability which may ensue from any cause whatsoever relating to the use of a booth by an exhibitor. Watchmen will be supplied, but MSNJ cannot guarantee exhibitors against loss. All valuable property should be insured by the exhibitor. MSNJ and the Committee on Scientific Exhibits, while permitting an exhibit, neither endorse nor assume any responsibility for the contents of such exhibit.

11. *Awards:* Exhibits will be judged on the basis of originality, excellence of correlating facts, and excellence of presentation.

12. *Admission:* Admission to the Scientific Exhibits is by badge only. The general public is not admitted.

These regulations have become a part of the agreement between the exhibitor and The Medical Society of New Jersey. They have been formulated for the best interests of all concerned, and the cooperation of the exhibitors will be deeply appreciated.

THE MEDICAL SOCIETY OF NEW JERSEY

208th Annual Meeting

HADDON HALL ATLANTIC CITY, NEW JERSEY

APPLICATION FOR SPACE IN THE SCIENTIFIC EXHIBITS

MAY 11-13, 1974

The Committee on Scientific Exhibits will furnish uniform, painted signs for each exhibit—if requested by exhibitor. Please fill in the following form carefully. (use *typewriter*, or *print*, please)

1. TITLE (Generic names only): .....

   .....

   Full Name and Degree of Exhibitor(s) .....

   .....

   City ..... State .....

   Institution (if desired) ..... City .....

   Aided by commercial or pharmaceutical company .....

   Exhibit constructed by: .....

2. DESCRIPTION OF EXHIBIT: Please give a brief statement telling the purpose of the exhibit, what it shows, and the conclusions reached—use generic names only. (This is for publication in the printed program.)

   .....

   .....

   .....

   .....

   .....

3. Is the exhibit free-standing or self-contained? .....
4. SIGN required: ..... SIGN not required: .....
5. Will backwall and dividers be required? (see sketch on reverse side): .....
6. SIZE OF BOOTH REQUESTED (See sketch on back) ABSOLUTE MAXIMUM: length 15', depth 6'.

   Desired inside clear backwall (8 to 15 feet) ..... Minimum inside clear blackwall .....
7. PHOTOGRAPH OR SKETCH of exhibit should accompany this application. .....
8. Has this exhibit been shown in whole or part at any other scientific meeting? .....

   If so, when? ..... and where? .....

   The undersigned agrees to abide by the regulations listed.

   Name .....

   Address .....

Date: ....

Return application to John J. Thompson, M.D., Chairman, Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM

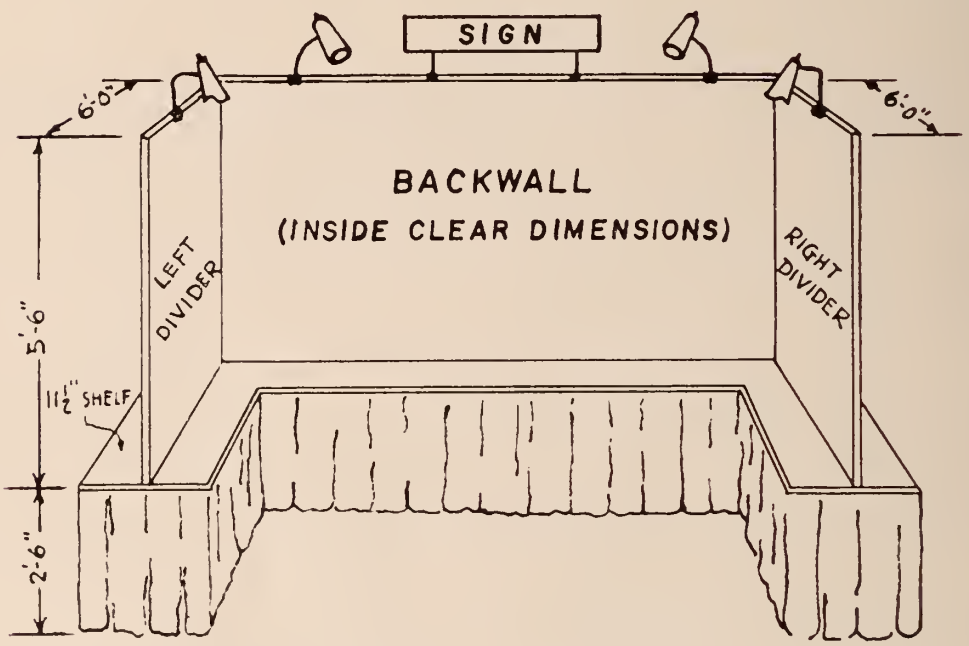
STANDARD EQUIPMENT REQUISITION FORM

Use this form only in connection with equipment to be supplied by the Committee on Scientific Exhibits. Equipment listed below will be provided at no charge to exhibitors. However, it is important that you anticipate your exact requirements in advance, as last minute changes are costly to the Society.

All scientific booths will be erected with backwall and dividers as illustrated below. Shelving and overhead lights are optional.

ILLUSTRATION OF TYPICAL BOOTH

(Booth construction: composition board covered with burlap)



Check appropriate boxes:	left divider		backwall		right divider	
Shelving	☐ yes	☐ no	☐ yes	☐ no	☐ yes	☐ no
Overhead lights	☐ yes	☐ no	☐ yes	☐ no	☐ yes	☐ no

If your exhibit will not require backwall, or left or right dividers, please advise.

If a sign is incorporated with your exhibit, please advise, and one will *not* be ordered for you.

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM

adjunctive therapy for wound debridement

HELPS TO REMOVE:

- Necrotic Tissue and Associated Odor

HELPS PREPARE WOUND FOR:

- Granulation/Healing
- Granulation/Grafting



CLEANSE WOUND
Thoroughly cleanse and irrigate wound area with sodium chloride or water solutions. Wound MUST be cleansed of antiseptics or heavy-metal antibacterials.



THOROUGHLY MOISTEN
Thoroughly moisten wound area either through tubbing, showering, or wet soaks (e.g., sodium chloride or water solutions).



APPLY ENZYME
Apply a layer of TRAVASE Ointment. Assure intimate contact with necrotic tissue and complete wound coverage.



APPLY MOIST DRESSING
Apply loose moist dressings (most important with dry leathery eschar).



CHANGE DRESSINGS
When changing dressing, gently wipe away the dissolved material. Repeat the procedure, including application of TRAVASE Ointment, 3 to 4 times per day for best results.

Travase® Ointment
brand of Sutilains



Indications
For wound debridement (1,2)—TRAVASE Ointment is indicated as an adjunct to established methods of wound care for biochemical debridement of the following lesions:

Second and third degree burns,
Decubitus ulcers,
Incisional, traumatic, and pyogenic wounds,
Ulcers secondary to peripheral vascular disease.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC
Deerfield, Illinois 60015

Please see next page for prescribing information.

Travase® Ointment brand of Sutilains

ulcers

TERRY V CARLE, M.D., CLINICAL INSTRUCTOR, DEPT OF PHYS. MED. & REHAB., CRAIG REHABILITATION HOSPITAL, UNIVERSITY OF COLORADO



Before treatment, necrotic matter coated the inner surfaces of this decubitus ulcer.



After nine days of TRAVASE therapy, debridement is nearly complete and granulation evident.

burns

DALE B. DUBIN, M.D., DIPLOMATE, AMERICAN BOARD OF PLASTIC SURGERY, TAMPA, FLORIDA



Before treatment . . .



48 hours following treatment with TRAVASE Ointment on right hand; left hand is control.

Travase® Ointment

(brand of Sutilains)

Indications: For wound debridement, TRAVASE Ointment is indicated as an adjunct to established methods of wound care for biochemical debridement of the following lesions:

- Second and third degree burns,
- Decubitus ulcers,
- Incisional, traumatic, and pyogenic wounds,
- Ulcers secondary to peripheral vascular disease.

Contraindications: Application of TRAVASE Ointment is contraindicated in the following conditions:

- Wounds communicating with major body cavities,
- Wounds containing exposed major nerves or nervous tissue,
- Fungating neoplastic ulcers,
- Wounds in women of child-bearing potential—because of lack of laboratory evidence of effects of TRAVASE upon the developing fetus.

Warning: Do not permit TRAVASE Ointment to come into contact with the eyes. If contact is made, immediately rinse with copious amounts of water, preferably sterile.

Precautions: A moist environment is essential to optimal activity of the enzyme. Enzyme activity may also be impaired by certain agents (see package insert). Although there have been no reports of systemic allergic reaction in humans, studies have shown that there may be an antibody response in humans to absorbed enzyme material.

Adverse Reactions: Consist of mild, transient pain, paresthesias, bleeding and transient dermatitis. Pain usually can be controlled by administration of mild analgesics. Side effects severe enough to warrant discontinuation of therapy occasionally have occurred.

If bleeding or dermatitis occurs as a result of the application of TRAVASE Ointment, therapy should be discontinued. No systemic toxicity has been observed as a result of the topical application of TRAVASE Ointment.

DOSAGE AND ADMINISTRATION: STRICT ADHERENCE TO THE FOLLOWING IS REQUIRED FOR EFFECTIVE RESULTS OF TREATMENT:

1. Thoroughly cleanse and irrigate wound area with sodium chloride or water solutions. Wound MUST be cleansed of antiseptics or heavy-metal antibacterials which may denature enzyme or alter substrate characteristics (e.g., hexachlorophene, silver nitrate, benzalkonium chloride, nitrofurazone, etc.).
2. Thoroughly moisten wound area either through tubbing, showering, or wet soaks (e.g. sodium chloride or water solutions).
3. Apply TRAVASE Ointment in a thin layer assuring intimate contact with necrotic tissue and complete wound coverage extending ¼ to ½ inch beyond the area to be debrided.
4. Apply loose wet dressings.
5. Repeat entire procedure 3 to 4 times per day for best results.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC
Deerfield, Illinois 60015

LETTER TO THE JOURNAL

Death of an Ethical Principle

September 17, 1973

Gentlemen:

Editorial: "The Temptation to Advertise"—The Journal of The Medical Society of New Jersey, September, 1973, Volume 70, No. 9. Mark it well! It signifies the death of the ethical gate that held back the flood of marginal physicians by freeing them of the bonds of medical ethics that formerly prevented the poor physician, who shouted the loudest, from drowning out the fine physician, content to let his abilities alone speak for him. To quote that editorial: "Furthermore, with current concern about the 'image' of the physician, one can defend giving publicity to the successes of the individual practitioners. Perhaps some of us may offer a requiem on the disappearance of a quaintly old-fashioned ethical principle, but this is one of the facts of life of 1973." Requiem indeed—border the editorial in black while we watch the PR men rush to newspapers, radio, television, magazines, and brochures to sing the praises of the "successes" of their individual client practitioneers.

The editorial mentioned the 1955 edition of the AMA's Principles of Medical Ethics as a discard of yesteryear and stated that the 1972 Principles simply omit any reference to advertising or self-aggrandizement. Now anything goes! It was convenient to overlook the fact that the AMA House of Delegates voted, in December 1970, to "urge local medical societies to take proper disciplinary action whenever physicians are involved in the solicitations of patients for any medical service."

The Supreme Court of Virginia found it clearly within the State's police power to enact reasonable measures ensuring that the medical health field be free of commercial practices and pressures. Other state medical societies have expressed similar views. New Jersey pioneers with a giant step backward.

This blessing from above is guaranteed to lead to a rapid deterioration and massive erosion of our prior high professional standards. Recently in Essex County, we were subjected to a series of newspaper articles with large pictures depicting medical and surgical "firsts." These photographs were complete with adoring patients grasping the hand of their "miracle" physicians as they gratefully exchanged smiles, secure in the knowledge that they were providing each other mutual benefits. All we are missing are the office hours of these shining examples of medical supermen; however, that information should be easily obtained from our advertising promoting Society. No matter how one colors it, advertising is the long condemned, but apparently now accepted, soliciting of patients which is no less than medical streetwalking. If this new principle is allowed to stand, get ready for a different brand of medical practice. we are now free to sell our "image" in any fashion conceived by whatever level of Madison Avenue brains we are able to afford. The race is on—or is it?

(signed) Maurice J. Leon, M.D.

Multiple Sclerosis Society

Patients with multiple sclerosis (and their families) should be told of the National Multiple Sclerosis Society. The only organization in southern New Jersey which is dedicated to both patient services and research is the chapter located at 792 Haddon Avenue, Collingswood, New Jersey 08108.

At no expense to the patients, this organization helps MS victims in supportive and educational ways by providing medical equipment (with a doctor's Rx), consultive and referral services, and a swimming-exercise program. For more information write to the Society.

Now there is a laxative/stool softener with a more effective, dual-action formula.



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CAPSULES

"GERI-CASAGRA"™ (CASANTHRANOL) 30 mg. • DIOCTYL SODIUM SULFOSUCCINATE 250 m

The unique Stimulax formula provides the ideal combination of a proven, gentle laxative with a sufficient dosage of stool softener for dependable, effective relief of constipation.

In most cases, one capsule before bedtime brings effective results **without straining or irritation . . . griping or cramps.**

AVAILABLE: Bottles of 30, 100 and 500 Soft Gelatin Capsules.

Samples on Request

GERIATRIC PHARMACEUTICAL CORP.

Floral Park, N.Y. 11001

Pioneers in Geriatric Research

DEVELOPERS AND SUPPLIERS OF CEVI-BID • GAYSAL • TESTAND-B

ANNOUNCEMENTS

Ophthalmology Colloquium

The New Jersey Academy of Ophthalmology and Otolaryngology will hold its annual meeting at the Robert Treat Hotel in Newark on November 14. The morning session will consist of two seminars—one in otolaryngology, cosponsored by the New Jersey Speech and Hearing Association, and the other in neuro-ophthalmology. The afternoon assembly will feature a program on cataracts. There is no charge but pre-registration is required; non-member fee is $25. Luncheon at 12 noon and a buffet dinner at 7 o'clock, preceded by a reception, are included. For further information, please write to the Eye Institute of New Jersey, 15 South 9th Street, Newark, New Jersey 07107.

Graduate Lectures in Surgery

The following programs have been announced for the 1973-1974 "Distinguished Lecture Series" offered by the Department of Surgery of the New Jersey Medical School, CMDNJ:

November 26	Small Bowel Resection and Gastric Hypersecretion John H. Landor, M.D., Professor Division of General Surgery Rutgers Medical School
December 10	Hiatus Hernia G. Robert Mason, M.D., Chairman Department of Surgery University of Maryland School of Medicine
January 28	Benign Lesions of the Breast William T. Fitts, Jr., M.D., Chairman Department of Surgery University of Pennsylvania School of Medicine
February 11	Metastatic Tumors of the Lung Paul C. Adkins, M.D., Chairman Department of Surgery George Washington University School of Medicine

Lectures are held at 4 p.m. in the amphitheater, 2nd floor, Martland Hospital, Newark. There is no charge. Guarded parking is available in parking lot M, 12th and Bergen Streets. For further information, please write to Eric J. Lazaro, M.D., Professor of Surgery, Martland Hospital Unit, CMDNJ, 65 Bergen Street, Newark 07107.

Graduate Courses in Medicine

The following schedule, in the series, "Advances in Medicine," has been announced by the Bergen Pines County Hospital, Paramus. Sessions are held in the hospital auditorium from 9:30 to 11 a.m. on the Wednesdays indicated and collation is offered at 9 o'clock. For further information write to the Office of Medical Education, Bergen Pines County Hospital, Paramus 07652.

November 14	Psychopharmacology George Simpson, M.D. Bergen Pines Hospital, Paramus
November 21	Preinfarction Angina Harvey G. Kemp, Jr., M.D. St. Luke's Hospital, New York
November 28	Carcinoembryonic Antigen Phenomenon and Cancer Immunology Hans J. Hansen, Ph.D. Hoffmann-LaRoche, Nutley
December 5	Urticaria and Angioedema David J. McConnell, M.D. College of Physicians and Surgeons, New York
December 12	Cushing's Syndrome Norman H. Ertel, M.D. VA Hospital, East Orange
December 19	Clinical Pathology Conference Edward Wagman, M.D. Bergen Pines County Hospital, Paramus

Psychiatric Graduate Programs

Fair Oaks Hospital in Summit, in cooperation with the Academy of Medicine of New Jersey, has arranged the following programs in the series, "Current Topics in Psychiatry:"

November 28	Thanatology Robert Cohen, M.D.
December 5	Hepatitis Willem Ten Hove, M.D.
December 19	Thyroid Diseases Theodore Dull, M.D.

Sessions are held from 3 to 4:30 p.m. (Wednesdays) at the hospital, 19 Prospect Street, Summit. Further information may be obtained from Granville L. Jones, M.D., Director of Research and Education.

Pulmonary Disease Conferences

Rutgers Medical School, in conjunction with the New Jersey Thoracic Society, the New Jersey Lung Association, and the Delaware-Raritan Tuberculosis and Respiratory Disease Association, announces the following pulmonary disease conferences during 1973-1974. Lectures are held at 1:00 p.m. on the Wednesdays indicated at the Link Conference Center, Rutgers Medical School in Piscataway. Discussion of clinical material will follow each presentation.

November 28	Controversy in Sarcoidosis Harold L. Israel, M.D. Jefferson Medical College
January 23	Pathogenesis of Emphysema Philip Kimbel, M.D. Einstein Medical Center (Philadelphia)
February 27	Management of Lung Cancer J. W. Mackenzie, M.D. Dean, Rutgers Medical School

Programs for March through June will be announced in a later issue. For additional information, please write to Norman H. Edelman, M.D., Chief, Pulmonary Diseases Division, Department of Medicine, Rutgers Medical School, CMDNJ, University Heights, Piscataway, New Jersey 08854.

Graduate Course in Ophthalmology

On December 5 and 6, 1973, in Cleveland, Ohio, a graduate course in ophthalmology will be presented by the Cleveland Clinic Educational Foundation. A star-studded faculty from the Mayo Clinic will read papers and lead panel discussions on retinal disease and retinal surgery, mid-facial trauma, neuro-opthalmology, oculoplastic lid surgery, and other subjects. The course is AMA accredited. Registration, which is limited, should be made by November 28th and is on a first-come basis. Fee is $80 and includes luncheon on each day—residents and interns $40. Advance hotel accommodations are advised. For further information, please write to the Cleveland Clinic, Education Division, 9500 Euclid Avenue, Cleveland, Ohio 44106.

Wills Eye Hospital Clinical Conference

The dates for the 26th Annual Clinical Conference of the Wills Eye Hospital are February 14 to 16, 1974 at the Bellevue-Stratford Hotel in Philadelphia. Symposia will include emergency eye care, management of diabetic retinopathy, and management of the aging eye and adnexa. Workshops will be held on refraction, glaucoma, neurology, cornea, and microsurgery.

Please address inquiries to Gerard Shannon, M.D., Chairman of the Annual Clinical Conference Committee, Wills Eye Hospital, 1601 Spring Garden Street, Philadelphia 19130.

EENT Lectures in Jerusalem

A ten-day conference on ophthalmology and otolaryngology will be held in Jerusalem, February 14 to 24, 1974. Lecturers from New York and from Israel will present papers on color blindness, night blindness, contact lens fitting, hereditary diseases causing blindness and deafness, external diseases of the eye, laryngeal stridor in infants, upper respiratory disease, early detection of deafness in children, mucormycosis of the nose, occupational diseases of the nose, and other topics. Registration fee is $100. Participants and their families can make their own travel arrangements or may take advantage of a tour package which is being arranged to include airline tickets, hotel reservations, and so on. For details, please write to Ms. Cynthia Vaughan-Soika, Projects Director, Symposia Medica Foundation, 305 East 24th Street, New York 10010.

Rhinology Courses in Chicago

During the week of March 31 to April 6, 1974, the American Rhinologic Society, in cooperation with the Illinois Masonic Medical Center (and, for part (c), the Illinois Medical Society), will present introductory courses in (a) functional corrective surgery of the nasal septum and the external nasal pyramid, (b) rhinomanometry and naso-antral manometry,

and (c) basic principles of respiratory physiology and fundamental diagnostic tests—pulmonary, cardiac, blood gas analysis, nasal function, and nasopulmonary. All sessions are held in Chicago and tuition is $350 for the full course; part (c) only is available for $50 and is open to all members of the medical profession. The courses are approved for credit by the Council of Medical Education of the AMA. For additional information, please communicate with the American Rhinologic Society, 4177 Broadway, Kansas City, Missouri 64111, or 530 Hawthorne Place, Chicago, Illinois 60657.

Ocular Trauma Conference

On April 22, 1974, at the Nassau County (Long Island) Medical Center, East Meadow, New York, the Long Island Ophthalmological Society will hold an all-day clinical conference on ocular trauma. A faculty of prominent ophthalmologists has been engaged. Fee for non-members is $25; residents will be admitted without charge. A dinner meeting, with guest speaker, will follow the symposium; there is an additional charge of $15 for this gathering. For further information, please write to M. G. Bruno, M.D., 737 Front Street, Hempstead, New York 11550.

Symposium on Medical Ethics in Israel

May 6 to 11, 1974, are the dates for an international symposium on "Medical Ethics in a Changing World," and the place is the Hebrew University—Hadassah Medical School in Jerusalem. Official language of the conference is English, and speakers will present the scientific, religious, legal, and philosophic aspects of medical ethics. Advance registration ($75 for participants; $30 for your spouse) is required and remittance should be sent to the International Symposium on Medical Ethics, P.O.B. 16271, Tel Aviv, Israel. Social activities have been planned and arrangements can be made for a post-congress tour of Israel. Information concerning the scientific program may be obtained by writing to Professor Charles R. Kleeman, Hadassah Medical School, P.O.B. 1172, Jerusalem, Israel.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1973
November

14 **CMDNJ—Rutgers Medical School Academy of Family Practice, and Academy of Medicine of New Jersey**
University Heights, Piscataway
Cardiology Conference (every Wednesday through June 1974)

14 **Clara Maass Hospital and Academy of Medicine of New Jersey**
Clara Maass Hospital, Belleville
Continuing Education Courses
(every Wednesday through December 5)

14 **Bergen Pines County Hospital and Academy of Medicine of New Jersey**
Bergen Pines Hospital, Paramus
Advances in Medicine
(every Wednesday through January 1974)

Middlesex General Hospital, American Academy of Family Practice, and Academy of Medicine of New Jersey
Middlesex General Hospital, New Brunswick

14 *Unusual Infections*

21 *Medical and Surgical Emergencies in Psychiatry*

14 **Essex County Mental Health Association**
Veterans Hospital, East Orange
Loeser Lecture—Schizophrenias

14 **Academy of Medicine of New Jersey**
John E. Runnells Hospital, Berkeley Heights
Electrolyte Imbalance

14 **Academy of Medicine of New Jersey and New Jersey Radiology Society**
Morristown Memorial Hospital, Morristown
Neuroradiology

14 **American Academy of Family Practice and Academy of Medicine of New Jersey**
St. Michael's Medical Center, Newark
Anemia and Bleeding Disorders of Pregnancy

15 **New Jersey Thoracic Society**
Mountainside Hospital, Montclair
Clinical Conferences

15 **Academy of Medicine of New Jersey and New Jersey Radiology Society**
Jersey City Medical Center
Therapy in Radiology

17 **Academy of Medicine of New Jersey**
Rutgers Medical School, Piscataway
Transitory Ischemia Attacks, Cerebral Vascular Insufficiency and Strokes

19 **Academy of Medicine of New Jersey**
Ancora Psychiatric Hospital, Hammonton
Drug Addiction

20 **Academy of Medicine of New Jersey**
Holy Name Hospital, Teaneck
Proper Use of Antibiotics

20 **Academy of Medicine of New Jersey**
Kessler Memorial Hospital, Hammonton
Fluid and Electrolyte Imbalance

21 **Helene Fuld Hospital and Academy of Medicine of New Jersey**
Helene Fuld Hospital, Trenton
Proteinuria and Nephrotic Syndrome

21 **Academy of Medicine of New Jersey**
Trenton Psychiatric Hospital, Trenton
Acupuncture

21 **Veterans Administration and CMDNJ**
Veterans Hospital, East Orange
Big ACTH Possible Biologic Marker in Pulmonary Carcinoma

21 **Academy of Medicine of New Jersey and St. Joseph's Hospital**
St. Joseph's Hospital, Paterson
Cardiac Arrhythmias

27 **Academy of Medicine of New Jersey**
Warren Hospital, Phillipsburg
Management of Renal Failure

28 **Academy of Medicine of New Jersey**
Helene Fuld Hospital, Trenton
Management of Renal Failure

28 **Academy of Medicine of New Jersey and New Jersey Allergy Society**
Holiday Inn, Woodbridge
Pharmacologic Topics

28 **Fair Oaks Hospital**
Fair Oaks Hospital, Summit
Thanatology

28 **Riverside, Dover General, and St. Clare's Hospitals**
Riverside Hospital, Boonton
Endoscopy and Colonscopy

28 **New Jersey Thoracic Society and Academy of Medicine of New Jersey**
JFK Hospital, Stratford
Fiberoptic Bronchoscopy

28 **New Jersey Thoracic Society**
Rutgers Medical School, Piscataway
Controversy in Sarcoidosis

28 **Academy of Medicine of New Jersey**
Rod's 1920 Roadhouse, West Orange
Cerebellum and Epilepsy

December

1 **American College of Surgeons**
Monmouth Medical Center, Long Branch
Seminar

4 **Academy of Medicine of New Jersey**
Holy Name Hospital, Teaneck
Difficult Diabetic Patient

Middlesex General Hospital, American Academy of Family Practice, and Academy of Medicine of New Jersey
Middlesex General Hospital, New Brunswick

5 *Stroke Prevention and Management*

12 *Acute Drug Intoxications*

19 *Determinants of Emotional Health*

Helene Fuld Hospital and Academy of Medicine of New Jersey
Helene Fuld Hospital, Trenton

5 *Hypertension*

19 *Endoscopy of Gastrointestinal Tract*

5 **Academy of Medicine of New Jersey**
Fair Oaks Hospital, Summit
New Concepts in Hepatitis

6 **Radiology Society of New Jersey and Academy of Medicine of New Jersey**
Hospital Center at Orange
Cystourethrography in Children

8 **Academy of Medicine of New Jersey**
Morristown Memorial Hospital, Morristown
Surgery of the Hand

10 **CMDNJ—New Jersey Medical College**
Martland Hospital, Newark
Hiatus Hernia

11 **Academy of Medicine of New Jersey**
Paul Kimball Hospital, Lakewood
Thyroid Diseases

12 **Riverside, Dover General and St. Clare's Hospitals**
Riverside Hospital, Boonton
Hepatitis B-Antigen and Chronic Liver Disease

12 **Academy of Medicine of New Jersey and New Jersey Radiology Society**
Morristown Memorial Hospital
Angiography

12 **Academy of Medicine of New Jersey**
Mountainside Hospital, Montclair
Surgery of Traumatized Hand

12 **Academy of Medicine of New Jersey**
Runnells Hospital, Berkeley Heights
Clinical Electrocardiography

18 **Academy of Medicine of New Jersey**
Holy Name Hospital, Teaneck
Proper Use of Blood Gases

19 **Academy of Medicine of New Jersey**
Trenton Psychiatric Hospital, Trenton
Fluid and Electrolyte Imbalance

19 **Academy of Medicine of New Jersey**
Fair Oaks Hospital, Summit
Thyroid Diseases

19 **Veterans Administration and CMDNJ**
Veterans Hospital, East Orange
Role of Respiratory Muscles in Respiratory Failure

1974
January

Middlesex General Hospital, American Academy of Family Practice, and Academy of Medicine of New Jersey
Middlesex General Hospital, New Brunswick

2 *Dermatology and the Clinician*

9 *Hemoptysis*

16 *Office Evaluation and Management of the New Hypertensive Patient*

23 *Medical Complications of Acute Myocardial Infarction*

30 *Surgical Considerations in Management of Myocardial Infarction*

8 **New Jersey Dermatological Society and Academy of Medicine of New Jersey**
Overlook Hospital, Summit
Genetic Disease and Inheritance Patterns

Helene Fuld Hospital and Academy of Medicine of New Jersey
Helene Fuld Hospital, Trenton

9 *Hepatitis*

16 *Acute Abdomen*

23 *Inflammation of Large Bowel*

10 **Academy of Medicine of New Jersey**
Helene Fuld Hospital, Trenton
Diagnosis In Treatment of Shock

16 **Academy of Medicine of New Jersey**
Trenton Psychiatric Hospital, Trenton
Alcoholism

16 **Academy of Medicine of New Jersey**
VA Hospital, East Orange
Respiratory Phenomena and Metabolic Acidosis

17 **Academy of Medicine of New Jersey**
Englewood Hospital, Englewood
Newer Concepts of Hepatitis

21 **Academy of Medicine of New Jersey**
Ancora Psychiatric Hospital, Hammonton
Medical-Surgical Emergencies in Psychiatric Practice

22 **Academy of Medicine of New Jersey**
Warren Hospital, Phillipsburg
Acupuncture

23 **New Jersey Thoracic Society**
Rutgers Medical School, Piscataway
Pathogensis of Emphysema

23 **Academy of Medicine of New Jersey**
Fair Oaks Hospital, Summit
Difficult Diabetics With Mental Illness

23 **Academy of Medicine of New Jersey and St. Joseph's Hospital**
St. Joseph's Hospital, Paterson
Clinical Symposia—Series II: Diabetes

24 **Radiological Society of New Jersey and Academy of Medicine of New Jersey**
Hospital Center at Orange
Venography of the Upper and Lower Extremities

28 **CMDNJ, New Jersey Medical College and Academy of Medicine of New Jersey**
Martland Hospital, Newark
Benign Lesions of the Breast

30 **Academy of Medicine of New Jersey**
College of Medicine and Dentistry, Newark
Use of Blood Products for Transfusion

February

5 **New Jersey Dermatological Society and Academy of Medicine of New Jersey**
St. Michael's Medical Center, Newark
Antibiotic Therapy

Middlesex General Hospital, American Academy of Family Practice, and Academy of Medicine of New Jersey
Middlesex General Hospital, New Brunswick

6 *Hormones, Hypertension, and Vascular Disease*

13 *Perspectives in Diabetes*

20 *Trends in Hyperalimentation*

27 *Biological Role of the Lymphocyte*

Helene Fuld Hospital and Academy of Medicine of New Jersey
Helene Fuld Hospital, Trenton

6 *Pancreatic Diseases*

27 *Respiratory Insufficiency*

11 **CMDNJ, New Jersey Medical College and Academy of Medicine of New Jersey**
Martland Hospital, Newark
Mestastatic Tumors of the Lung

12 **New Jersey Dermatological Society**
Mountainside Hospital, Montclair
Use and/or Abuse of Antibiotic Therapy

12 **Academy of Medicine of New Jersey**
Paul Kimball Hospital, Lakewood
Diagnosis and Treatment of Hypertension

18 **Academy of Medicine of New Jersey**
Ancora Psychiatric Hospital, Hammonton
Medical Legal Aspects of Medicine and Surgery

20 **Academy of Medicine of New Jersey**
VA Hospital, East Orange
Resistance to Pulmonary Infection

20 **Academy of Medicine of New Jersey and St. Joseph's Hospital**
St. Joseph's Hospital, Paterson
Clinical Symposia—Series VI: Neurology

20 **Academy of Medicine of New Jersey**
Helene Fuld Hospital, Trenton
Acupuncture

21 **Academy of Medicine of New Jersey**
Englewood Hospital, Englewood
Laboratory Interpretations

26 **Academy of Medicine of New Jersey**
Warren Hospital, Phillipsburg
Diagnosis in the Anemic Patient

27 **New Jersey Thoracic Society**
Rutgers Medical School, Piscataway
Lung Cancer

28 **Radiological Society of New Jersey and Academy of Medicine of New Jersey**
Hospital Center at Orange
Tumors of the Small Bowel

March

Middlesex General Hospital, American Academy of Family Practice, and Academy of Medicine of New Jersey
Middlesex General Hospital, New Brunswick

6 *Paraneoplastic Syndromes*

13 *Neurological Complications of Systemic Cancer*

20 *Metabolic Bone Disease*

27 *Untoward Effects of Long-Term Steroid Therapy*

12 **New Jersey Dermatological Society and Academy of Medicine of New Jersey**
Barnert Hospital, Paterson
Host Defenses in Malignant Melanoma

12 **Academy of Medicine of New Jersey**
Paul Kimball Hospital, Lakewood
Medical Legal Aspects of Medicine and Surgery

13 **Academy of Medicine of New Jersey**
Hunterdon Medical Center, Flemington
Infectious Diseases

16 **New Jersey Chapter, American Academy of Family Physicians**
Cherry Hill, Inn, Cherry Hill
Annual Meeting

20 **Academy of Medicine of New Jersey**
Trenton Psychiatric Hospital, Trenton
Drug Addiction

21 **Academy of Medicine of New Jersey**
Englewood Hospital, Englewood
Proper Use of Antibiotics

24 **CMDNJ—New Jersey Medical School and Academy of Medicine of New Jersey**
Location to be announced
Problems in Obstetrics and Gynecology

26 **Academy of Medicine of New Jersey**
Warren Hospital, Phillipsburg
Diagnosis in Neurology and Neuro-Surgery

28 **Radiological Society of New Jersey and Academy of Medicine of New Jersey**
Hospital Center at Orange
Lumbar Spondylosis

April

Middlesex General Hospital, American Academy of Family Practice, and Academy of Medicine of New Jersey
Middlesex General Hospital, New Brunswick

3 *Eye Care in Family Practice*

10 *Gynecological Problems in Office Practice*

17 *Emergencies of Pregnancy and Labor*

24 *Pulmonary Function Testing*

4 **Academy of Medicine of New Jersey**
Helene Fuld Hospital, Trenton
New Developments in Scanning

10 **Academy of Medicine of New Jersey**
Runnells Hospital, Berkeley Heights
Acupuncture

15 **Academy of Medicine of New Jersey**
Ancora Psychiatric Hospital, Hammonton
Alcoholism

17 **Academy of Medicine of New Jersey and St. Joseph's Hospital**
St. Joseph's Hospital, Paterson
Clinical Symposia—Series VIII: Hypertension

18 **Academy of Medicine of New Jersey**
Englewood Hospital, Englewood
Bleeding Diseases

23 **Academy of Medicine of New Jersey**
Warren Hospital, Phillipsburg
Differential Diagnosis of Arthritis

25 **Radiological Society of New Jersey and Academy of Medicine of New Jersey**
Hospital Center at Orange
Total Body Scanning

May

Middlesex General Hospital, American Academy of Family Practice, and Academy of Medicine of New Jersey
Middlesex General Hospital, New Brunswick

1 *Environmental Cancer in the Year 2000*

8 *Unusual Causes of Heart Failure*

15 *Hemorrhagic and Septic Shock*

22 *Developments in Infectious Diseases*

29 *ENT in Office Practice*

11-14 **The Medical Society of New Jersey**
Haddon Hall, Atlantic City
Annual Meeting

22 **Academy of Medicine of New Jersey**
Trenton Psychiatric Hospital, Trenton
Suicide

23 **Radiological Society of New Jersey and Academy of Medicine of New Jersey**
Hospital Center at Orange
Arthrography

24 **CMDNJ— New Jersey Medical School and Academy of Medicine of New Jersey**
Location to be announced
Management of the Fetus at Rest

29 **CMDNJ—New Jersey Medical School and Academy of Medicine of New Jersey**
Location to be announced
The Problem Fetus

June

17 **Academy of Medicine of New Jersey**
Ancora Psychiatric Hospital, Hammonton
Diagnosis in Neurology and Neurosurgery

20 **Academy of Medicine of New Jersey**
Helene Fuld Hospital, Trenton
Diagnosis in the Anemic Patient

25 **Academy of Medicine of New Jersey**
Warren Hospital, Phillipsburg
Sarcoidosis

OBITUARIES

Dr. Joseph Berke

Word has just been received of the death on August 1, 1973, of Joseph Berke, M.D., a Jersey City surgeon. Dr. Berke received his M.D. degree from New York Medical College in 1947 and did graduate work in surgery at New York University, Knickerbocker Hospital, and Jennings Hospital in Brooklyn. Upon his discharge from the military, he accepted an appointment as instructor in surgery at New York Medical College before moving to Hudson County in 1959 for the private practice of his specialty. Dr. Berke was a Diplomate in Surgery, and a member of the International College of Surgeons and the American Society of Abdominal Surgeons. He was on the staff at the Medical Center, St. Francis Hospital, and Christ Hospital in Jersey City.

Dr. Cyril I. Hutner

On September 13, 1973, Cyril I. Hutner, M.D., a well-known Middlesex County surgeon, died, at the age of 63. Dr. Hutner had been director of the surgical department at Perth Amboy General Hospital since 1957, and was president of the medical staff from 1969 to the present. He was also attending in surgery at the JFK Hospital in Edison. His M.D. degree came from Boston University Medical School in 1935 and he did graduate work in surgery at Harvard Medical School and the University of Minnesota, before coming to Perth Amboy in 1937. Dr. Hutner was a Fellow of the International College of Surgeons and a member of the Board of Managers of the American Cancer Society. He had been active in the affairs of the Middlesex County Medical Society.

Dr. James G. Langford

Word has just been received of the death on July 11, 1973, of James G. Langford, M.D., a member of the Gloucester County Medical Society. Born in 1909, Dr. Langford was a graduate of Hahnemann Medical College, class of 1934, and spent most of his career in the military, retiring from the Medical Corps of the Air Force with the rank of Colonel in 1967. He then served as school physician for Glassboro public schools and in 1969 opened an office for general practice in Pitman. He was board certified in preventive medicine (aviation medicine), a Fellow of the American College of Preventive Medicine in Aviation Medicine, a member of the Aerospace Medical Association and of the Society of Flight Surgeons. Dr. Langford was granted a master of public health degree from Harvard University in 1957.

Dr. Dominick Marini

One of Passaic County's senior members, Dominick Marini, M.D., died on September 1, 1973, at the age of 79. Dr. Marini was a graduate of the Long Island College of Medi-

cine, class of 1918, and practiced surgery in the Passaic area for many years. Before retirement he was on the staff at the Beth Israel Hospital in Passaic. He was a Fellow of the International College of Surgeons and had been active in the affairs of the Passaic County Medical Society.

Dr. Harry W. Mickey

On September 3, 1973, one of Essex County's well-known general practitioners, Harry W. Mickey, M.D., died at the age of 70. A 1930 graduate of Howard University Medical School, Dr. Mickey had practiced in Maplewood for 41 years. He was on the staff at St. Barnabas Medical Center in Livingston and was a member of the American Academy of Family Practice. He had been a member of the Public Health Council of the New Jersey Department of Health since 1971.

Dr. Eugene F. Mullin

Word has just been received of the death on August 13 of Eugene F. Mullin, M.D., a general practitioner from Newark. Born in 1908, Dr. Mullin was graduated from St. Louis University Medical School in 1933 and returned to his native New Jersey the following year to establish a practice. He took graduate work in cardiology at Harvard and Cornell Medical Schools, and was on the attending staff at St. James Hospital in Newark before retirement.

Dr. Peter R. Pillone

Death on August 31, 1973, cut short the career of Peter R. Pillone, M.D., a neurosurgeon from Bergen County. He received his M.D. degree in 1959 from Boston University School of Medicine and following residency in surgery accepted a research fellowship in neurosurgery at Upstate Medical Center. He served with the Veterans Administration for several years as assistant chief in the department of neurosurgery at Kingsbridge VA Hospital in Bronx, New York. Dr. Pillone came to Bergen County for the private practice of his specialty in 1966. He was a diplomate in neurosurgery, a Fellow of the American College of Surgeons, and a member of the New Jersey Society of Neurosurgeons. Dr. Pillone was on the staff at Holy Name Hospital in Teaneck, Pascack Hospital in Westwood, and the Hackensack Hospital. He was only 44 years old at the time of his death.

Dr. Albert N. Siegel

At the untimely age of 45, Albert N. Siegel, M.D., was killed in a fire on September 1, 1973, while vacationing in Denmark. Dr. Siegel was a graduate of Temple University College of Medicine, class of 1956, and had practiced gastroenterology in Essex County for twelve years. He was chief of the department of gastroenterology at United Hospitals of Newark, and a member of the attending staff at Martland Hospital, Newark, and at St. Barnabas Medical Center in Livingston. Dr. Siegel was clinical professor of Medicine at the New Jersey Medical School, CMDNJ, and was a member of the American College of Physicians, the New Jersey Gastroenterological Society, and the Academy of Medicine of New Jersey.

Dr. Amadeo Turi

One of Newark's senior physicians, Amadeo E. Turi, M.D., died on August 7, 1973, at the age of 74. Born in Italy, Dr. Turi was graduated from Bellevue Hospital Medical College in 1899, and practiced in Newark for 49 years. He was an internist and had been on the staff at Presbyterian and Columbus Hospitals in Newark. He was a member of the Academy of Medicine of New Jersey and the New Jersey Diabetes Association, and had been active in the affairs of the Essex County Medical Society.

Dr. Oscar Ulan

One of Essex County's senior practitioners, Oscar Ulan, M.D., died on August 10, 1973, at the age of 74. Born and educated in Russia—his medical degree was granted by the University of Odessa, 1922—Dr. Ulan came to the United States in 1925 and worked full time in industrial medicine. He was board certified in preventive medicine—occupational medicine, and had staff appointments at St. Michael's and St. James' Hospitals. He was a Fellow of the American Industrial Medical Association.

BOOK REVIEWS

The First Five Years. Virginia E. Pomeranz, M.D. and Dodi Schultz. Garden City, New York, Doubleday, 1973. Pp. 248 ($6.95)

Both Dr. Pomeranz and I have been in pediatric practice for twenty years. It is extraordinary to me how similar our experiences have been. I have learned, done, and said many things during these years that I believed were uniquely my own. Now I find a fantastic number of my discoveries in Dr. Pomeranz's book.

Here is presented a decent, fair, and reasonable approach to the early childhood experience consistent with the popular mutual respect approach. Physicians can and should encourage parents to read this work and not fear that orthodox medical teaching and practice will be sabotaged in any way.

The book is notable in its ability to be so complete in so few pages. I have very few negative comments. A section on why people should have children and expectations from parenthood would have been desirable and useful.

Parents are told to tell the truth. Yet on page 154 we read about the shrewd couple who take their children to a toy store to look around and tell the children that the toys are not for sale. I feel that Dr. Pomeranz recommends too many checkups for well children. The section on other helpful reading could be longer. Early in the book parents are enjoined to "trust your own instincts." This may be a "come-on" in an attempt to get the reader to relax and to become open to the rest of the story. In reality Dr. Pomeranz feels strongly about many issues and expresses these feelings. I think she would rather have the reader listen to her advice than "trust your own instincts" and so would I. Advice is better than the seat of the pants instinctual method of child raising. Advice should be listened to. How then can parents be convinced? This book may help, but the problem of getting people to do what they know is right still has to be solved.

Solomon J. Cohen, M.D.

Orthopedic Surgery in the Zone of Interior. William S. Mullins, Col., MSC, Editor-in-Chief. Washington, D.C., Department of the Army, 1970. Pp. 1099. Illustrated. (Price not given)

This is the third and final volume covering orthopedic surgery in World War II. The other volumes covered experiences in the Mediterranean theater and in the European theater. This volume contains details of the final stage in the management of combat wounds received from all theaters and the bulk of non-combat conditions. It also contains much administrative material of interest only to military surgeons, but as the apology is stated in the foreword, "In the Army, standardization is the basis of all therapy."

After "D Day" (March 1945) an average of 1,200 casualties *per day* were being received in the U. S. from overseas. Of these, 30 to 45 per cent were compound fractures. That the great majority arrived here in very good medical condition, considering their wounds, is a tribute to the high caliber of attention they received at forward medical facilities.

This is an excellent volume, but not for the casual reader. For a student of military medicine it contains a thorough, lucid, and candid chronicle for the end-stage in the treatment of orthopedic wounds. For the practicing orthopedist, it provides a clear historical documentary showing how many basics of orthopedic treatment have evolved. The section on amputations is especially good. That the overwhelming tragedy of war can bring forth some lasting good for mankind is in itself remarkable. One can only wish that the political and diplomatic professions could learn as much from war as the medical profession already has.

Peter N. Carbonara, M.D.

We Mainline Dreams. Judianne Densen-Gerber, J.D., M.D. New York, Doubleday, 1973. Pp. 421. ($9.95)

Odyssey House is the name of a chain of 33 residential centers for drug addicts. The founder was Judianne Densen-Gerber, who is both a physician and an attorney. The therapeutic program is centered on group activities and Dr. Densen-Gerber strongly opposes methadone. She asserts that her program works for 80 per cent of those who stay with it for 6 weeks or more. She has had a good deal of flack from governmental figures and advocates of the more conventional rehabilitation programs. She characterizes politicians as "incompetent on all levels except game-playing, corrupt, worthless, and thoroughly nasty."

The book is flavored by many autobiographic sketches, including a detailed one of Dr. Densen-Gerber herself, news clippings, drawings, poems, Odyssey House schedules, and other documents. The program is highly structured and both front and back end papers of the book display a table of organization that looks like charts portraying complex government agencies. Unhappily, the publishers have not included an index which makes it hard to use the book for reference purposes. Toward the end of the volume, the author says that "our beautiful nation is dying and I don't think the government gives a damn." Thus, this work presents a peculiar combination of doomsday predictions and hope for the conquest of the drug problem. In general, the book is dramatic, not to say melodramatic at times, well-paced, and interesting.

Henry A. Davidson, M.D.

Building a National Health-Care System. New York Committee for Economic Development, 1973. Pp. 105. (Softback — $1.75)

The problems of the distribution of health care resources are popular discussion topics today. This is a report of a study of the Research and Policy Committee of the National Committee for Economic Development. The major cause of inadequacies in our distribution of medical care is found to be "faulty allocation of resources." The Committee recommends an integrated national health insurance program, "which should be continuous without interruptions during a hiatus in employment," and that "treatment should not be delayed for determination of liability for payment." The Committee looks for a "greatly accelerated development of ambulatory primary-care centers" with financing based on federal grants, loan guarantees, prepayment for an essential set of benefits." This thick text goes into considerable detail about the structure and funding of such programs. It is a solid reference work on the subject.

Leo J. Barone, M.D.

Current Diagnosis and Treatment. Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. Los Altos, California, Lange, 1973. Pp. 996. ($12—softback)

These indefatigable editors have produced another in a long series of compendia in soft binding which the working practitioner will find a welcome addition to his library. The book is divided, as most of the type are, into chapters by organ systems, infectious diseases, chemotherapeutic agents, poisons, cancer, immunology, and the like. Essentials of diagnosis are given, as are clinical and laboratory findings, complications, and therapy. In these respects it differs little from others of its genus.

The binding is sturdy and the type easily legible. When I reviewed the 1970 issue it contained about 100 fewer pages and weighed about one-half pound less.

This reviewer cannot help wondering if the publishers have not reached the point of diminishing returns. The size of the book and its cost approach that of a standard text such as "Cecil-Loeb," and the prospective purchaser must consider that an additional small investment might give him a much more vauable reference, albeit not quite so timely.

Leo Lewin, M.D.

Medical Aphorisms of Moses Maimonides. Translated and Edited by Fred Rosner, M.D. and Suessman Muntner, M.D., 2 Vols., New York, Yeshiva University Press, 1970, 1971

In recent years the word "classic" has lost so much of its prestige, that one hesitates to use it. Yet what other appropriate term can we find to describe a work which has managed to survive for almost eight hundred years, and is now presented to us in an English translation for the first time? Having circulated in manuscript for three centuries *Aphorisms of Moses Maimonides* (1135-1204) finally appeared in print as an incunabulum in 1489. It may thus lay claim to an extraordinary career of usefulness for generations of medical students.

The genius of Maimonides ranged far beyond the world of medicine. He was busily occupied with a large and demanding practice but found time to keep abreast of current advances in mathematics and astronomy, to compile the definitive codification of the vast encyclopedia of Jewish law, known as the Talmud, and to write the profound "Guide to the Perplexed" in which he undertook the task of reconciling certain tenets of Aristotle with ideas expressed in the Bible and Talmud. For writing the latter treatise he incurred the wrath of the orthodox rabbis, but won posthumous praise from St. Thomas Aquinas and other Christian philosophers when they later engaged in similar works on apologetics.

In the volumes at hand, we find 1500 aphorisms that have been abstracted largely from the voluminous writing of Claudius Galen (d.199 A.D.), whose theories continued to dominate medical thought during the Middle Ages and the early Renaissance. The generally respectful attitude which Maimonides at first shows toward his greater predecessor is not maintained throughout the books. Instead he becomes increasingly critical, citing many instances where his own observations have led him to disagree with the words of the Master. Indeed the twenty-fifth treatise (apparently unrevised and left in a state of disorder at the time of Maimonides' death) refers slightingly to many inconsistencies in the works of Galen, to his misunderstanding of Aristotelian logic, to his conceit in speaking out unadvisedly on non-medical matters, and to his misguided views on the creation of the world. This last treatise therefore holds great interest for students of medieval philosophy as a final restatement of Maimonides' opinions on many controversial issues.

This book requires some orientation in Arabic medical history and terminology. Once the reader has found his way through the underbrush of the medieval vocabularly, he can only admire the keenness of mind and powers of observation exhibited by Maimonides, his refusal to accept authority blindly, his fervid effort to find a genuine harmony between faith and science, and his firm belief in the usefulness of every organ of the body as being part of a Divine plan. For the student of medical history who wishes to read only one original work of the period this exceptional product of the medieval mind is highly recommended.

If we are to believe Dr. Rossner implicitly, Maimonides had some vague concept of the lesser circulation, capillaries, myocardial infarction and a large number of morbid entities which later generations were to identify more clearly. Through this English version of the *Aphorisms* Maimonides will find many new admirers. The book itself merits honorable position on the scholar's shelf alongside the prototypal *Aphorisms of Hippocrates* and its almost invariable accompaniment, the *Commentary of Galen*.

Morris H. Saffron, M.D.

Galaxies of Life. The Human Aura in Acupuncture and Kirlian Photography. Edited by Stanley Krippner and Daniel Rubin. New York, Interface, 1973. Pp. 182. Illustrated. (Price not stated.)

This book is a compendium of strange essays by an even stranger assortment of authors. Are you interested in the meridian ductal system as depicted by the Kirlian photographers—or perhaps positive and negative Yang and Yin? Would you like to read of the debate of bioplasma versus corona discharge? My trialectic processes must be impaired, and I have Byo-Ki, but this parapsychology is not for me. The appeal of this collection of pseudoscientific hodgepodge is limited to physicians who are followers of Wilhelm Reich's orgone theories. I'm afraid the only value in this book is in its recycling.

Seymour F. Kuvin, M.D.

Standard First Aid and Personal Safety. American National Red Cross. Garden City, New York, Doubleday, 1973. Pp. 268. Illustrated. (Softback—$1.95; Hardback —$3.50)

This 1973 edition of the standard Red Cross textbook is a true gem, updating instruction primers which have been used in first aid instruction classes since the early 1900's. Every conceivable emergency situation is covered, including wounds of every part of the body, shock, respiratory emergencies, heart attacks, and exposure to excessive heat and cold.

Of particular interest to this reviewer were the sections on the use of tourniquets, resuscitative techniques. C-P-R, poisons, drug abuse, and burns. No fault could be found with the information given in the discussion of these subjects, a tribute to the contributing editors' care and timeliness.

The volume will be of great interest and use to first aid squads and those members of the general public interested in basic first aid.

Joseph Peyser, M.D.

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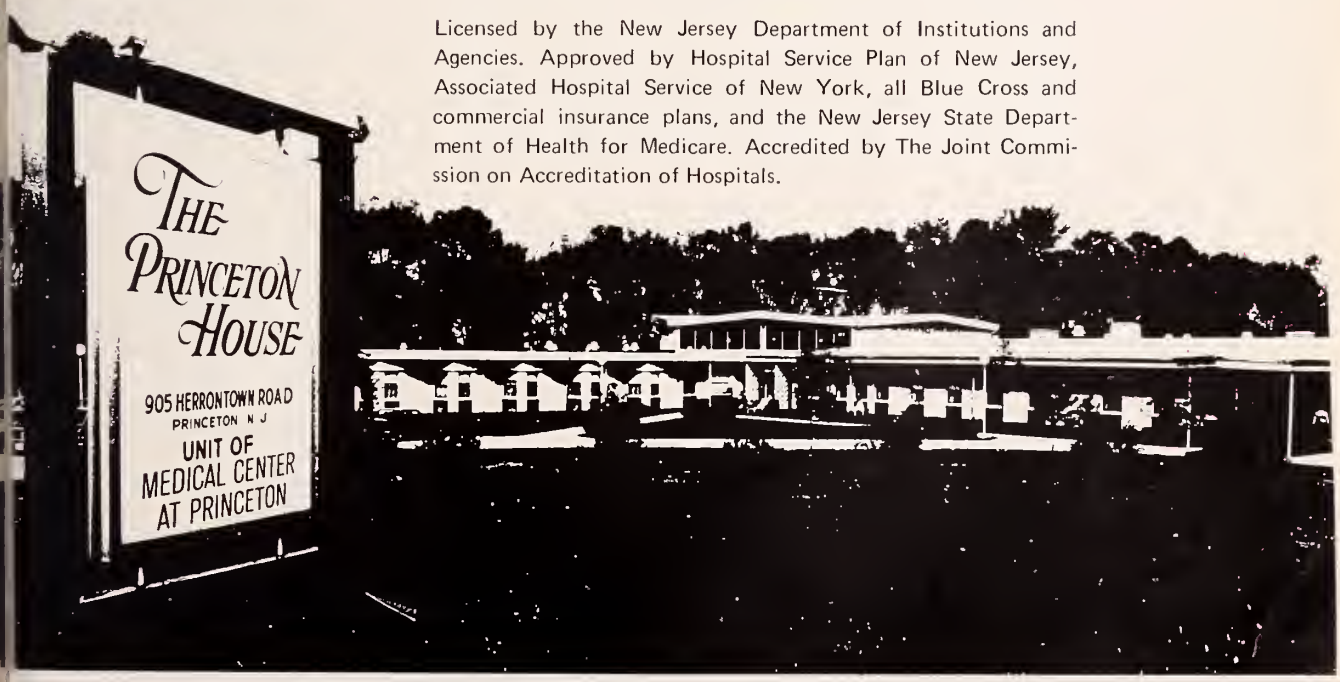
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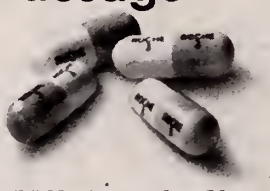
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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possibl combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, cauti patients against hazardous occupations requirin complete mental alertness (*e.g.*, operating machi ery, driving). Though physical and psychologica dependence have rarely been reported on recom mended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (includi convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnan lactation, or in women of childbearing age requir that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitatec and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing grad ally as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibito and phenothiazines. Observe usual precautions i presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulati and acute rage) have been reported in psychiatri patients and hyperactive aggressive children. Employ usual precautions in treatmer states with evidence of impending de suicidal tendencies may be present an measures necessary. Variable effects o coagulation have been reported very patients receiving the drug and oral a lants; causal relationship has not bee clinically.

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Remember that Tandearil is not a simple analgesic. It should not be used on patients responding to routine therapy. Before using, please read the prescribing information. It's summarized below.

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Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

Indications: Acute gouty arthritis, rheumatoid arthritis, rheumatoid spondylitis.

Contraindications: Children 14 years or less; senile patients; history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existence of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.

(B)98-146-800-F (10/71)

For complete details, including dosage, please see full prescribing information.

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The Weight of Professional Opinion

It's time for action to defend the laws and regulations that protect your patients against drug substitution.

These professional and trade organizations are united in supporting antisubstitution statutes and regulations:

The American Academy of Dermatolog

The Board of Directors of the American Academy of Family Physicians

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The Committee on Drugs of the American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the American College of Obstetricians and Gynecologists

The Board of Regents of the American College of Physicians

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The Board of Trustees of the American Medical Association

The American Psychiatric Associatio

The Executive Committee of the National Association of Retail Druggists

The Board of Directors of the Pharmaceutical Manufacturers Association

The National Wholesale Druggists' Association



ɔint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is) affirm the support of the participat- ıg organizations for the laws, regula- ons and professional traditions which rohibit the unauthorized substitution f drug products.

Traditionally, physicians, den- sts and pharmacists have worked ɔoperatively to serve the best inter- sts of patients. Productive coopera- on has been achieved through ıutual respect as well as a common oncern for the ideals of public ervice. This mutual respect has been eflected, in part, by joint support ver the years for the adoption and nforcement of laws and regulations pecifically prohibiting unauthorized ubstitution and encouraging joint iscussion and selection of the ource of supply of drug products. he basic principles of medical, den- al and pharmacy practice are thus tilized and preserved in the interest f patient welfare.

The antisubstitution laws have ot obstructed enhancement of the rofessional status of pharmacy any ıore than they have in and of them- elves guaranteed absolute protec- on from unsafe drugs, or freed hysicians, dentists and pharmacists rom their responsibilities to patients. s a practical matter, however, such aws and regulations encourage inter- rofessional communications regard- ıg drug product selection and assure ach profession the opportunity to xercise fully its expertise in drug sage, to the advantage of patients.

Physicians and dentists should e urged to increase the frequency nd regularity of their contacts with harmacists in selection of quality rug products, recognizing that economies to patients can be im- proved through such communica- tion, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physi- cians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selec- tion remain primary and do not per- mit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved under- standing and cooperation among the professions continue to grow.

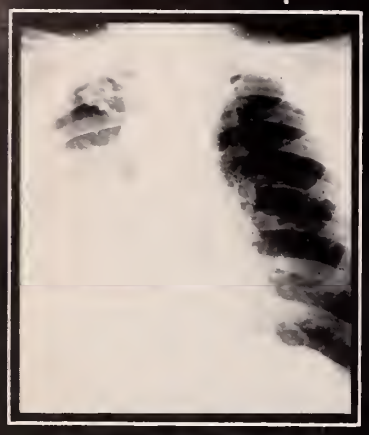
There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthor- ized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

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*AVAILABLE ON REQUEST: Ronald I. Goldberg, M.D. & Franklin I. Shuman, M.D. Double-blind study on the treatment of mentally confused patients. Reprinted from the Journal of the American Geriatrics Society, Vol. XII, No. 6, June 1964

Recommendations† on Combination Live Virus Vaccines

American Academy of Pediatrics

Committee on Infectious Diseases

In the September 15, 1971 *AAP Newsletter* sent to Academy members, the Committee on Infectious Diseases of the American Academy of Pediatrics stated its recommendations on the use of combination live virus vaccines. After a careful review of available data, the committee concluded that:

- "This information indicates that the products are both safe and effective when used as directed."
- The vaccine "...can, therefore, be recommended with the obvious advantages of reduction in the number of injections for any given child and a concomitant decrease in the required visits to a physician's office or clinic."



†For complete text of both recommendations see your MSD representative or write to Professional Service Dept., Merck Sharp & Dohme, West Point, Pa. 19486.

United States Public Health Service

Advisory Committee on Immunization Practices

In the April 24, 1971 issue of *Morbidity and Mortality Weekly Report,* the Advisory Committee on Immunization Practices of the United States Public Health Service presented recommendations on the use of combination live virus vaccines. The committee stated that:

- "Data indicate that antibody response to each component of these combination vaccines is comparable with antibody response to the individual vaccines given separately.
- "There is no evidence that adverse reactions to the combined products occur more frequently or are more severe than known reactions to the individual vaccines (see pertinent ACIP recommendations).
- "The obvious convenience of giving already selected antigens in combined form should encourage consideration of using these products when appropriate."

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MSD suggested immunization schedule for well babies

Age	Vaccine(s)
2 months	DPT (diphtheria-pertussis-tetanus) Oral poliomyelitis vaccine (triple)
3 months	DPT[1]
4 months	DPT Oral poliomyelitis vaccine (triple)
6 months	Oral poliomyelitis vaccine (triple)
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1. This vaccination may be given at 3 months, 5 months, or at 6 months, depending on your preference or on the condition of the child.

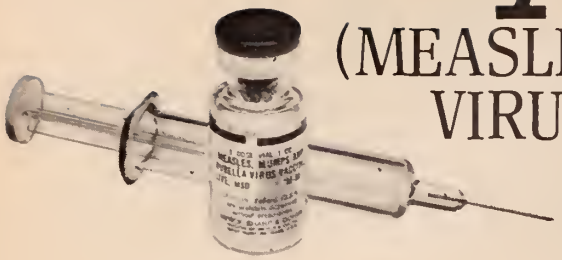
Since vaccination with a live virus vaccine may depress the results of a tuberculin test for four weeks or longer, the test and the vaccine should not be given during the same office visit.

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For a brief summary of prescribing information, please see following page.

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Contraindications: Pregnancy or possibility of pregnancy within three months following vaccination; infants less than one year old; sensitivity to chicken or duck, chicken or duck eggs or feathers, or neomycin; any febrile respiratory illness or other active febrile infection; active untreated tuberculosis; therapy with ACTH, corticosteroids, irradiation, alkylating agents, or antimetabolites; blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems; gamma globulin deficiency, i.e., agammaglobulinemia, hypogammaglobulinemia, and dysgammaglobulinemia.

Precautions: Administer subcutaneously; *do not give intravenously.* Epinephrine should be available for immediate use should an anaphylactoid reaction occur. Should not be given less than one month before or after immunization with other live virus vaccines, with the exception of monovalent or trivalent poliovirus vaccine, live, oral, which may be administered simultaneously; vaccination should be deferred for at least three months following blood transfusions or administration of more than 0.02 ml immune serum globulin (human) per pound of body weight, or human plasma.

Due caution should be employed in children with a history of febrile convulsions, cerebral injury, or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur 5 to 12 days after vaccination.

Excretion of the live attenuated rubella virus from the throat has occurred in the majority of susceptible individuals administered the rubella vaccine. There is no definitive evidence to indicate that such virus is contagious to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, has not been regarded as a significant risk.

Attenuated live virus measles, mumps, and rubella vaccines, given separately, may temporarily depress tuberculin skin sensitivity; therefore, if a tuberculin test is to be done, it should be scheduled before vaccination, to avoid the possibility of a false negative response.

Before reconstitution, refrigerate vaccine at 2–8 C (35.6–46.4 F) and *protect from light.* Use only diluent supplied to reconstitute vaccine. If not used immediately, return reconstituted vaccine to refrigerator at 2–8 C (35.6–46.4 F), and discard after eight hours.

Adverse Reactions: To date, clinical evaluation has not revealed any adverse reactions peculiar to the combination. The adverse reactions that occurred were limited to those that have been reported previously for the component vaccines.

Fever, rash; mild local reactions such as erythema, induration, tenderness, regional lymphadenopathy; parotitis; thrombocytopenia and purpura; allergic reactions such as urticaria; arthritis, arthralgia, and polyneuritis.

Occasionally, moderate fever (101–102.9 F); less commonly, high fever (above 103 F); rarely, febrile convulsions.

Encephalitis and other nervous system reactions that have occurred very rarely with the individual vaccines ma also occur with the combined vaccine. Experience fro more than 44 million doses of all live measles vaccin given in the U.S. by mid-1971 indicates that significa central nervous system reactions such as encephaliti occurring within 30 days after vaccination, have bee temporally associated with measles vaccine appro mately once for every million doses. In no case has been shown that reactions were actually caused by va cine. The Center for Disease Control has pointed ou that "a certain number of cases of encephalitis may b expected to occur in a large childhood population in defined period of time even when no vaccines are a ministered. A survey conducted in New Jersey in 19 showed that 2.8 cases of encephalitis (of unknow cause) occurred per million children, ages 1–9 years p 30-day period." However, the Center for Disease Co trol has analyzed the reported reactions followin measles vaccines and pointed out that "the clusterin of cases in the period 6 through 13 days after inocula tion as well as the recovery of measles virus (probabl the vaccine strain) from the CSF of one patient doe suggest that some of these cases may have been cause by the vaccine." The risk of such serious neurologica disorders following live measles virus vaccine adminis tration remains far less than that for encephalitis wit measles (one per thousand reported cases).

Transient arthritis, arthralgia, and polyneuritis are fea tures of natural rubella and vary in frequency and se verity with age and sex, being greatest in adult female and least in prepubertal children. Such reactions hav been reported with live attenuated rubella virus vac cines. Symptoms relating to joints (pain, swelling, stiff ness, etc.) and to peripheral nerves (pain, numbness tingling, etc.) occurring within approximately tw months after immunization should be considered as pos sibly vaccine related. Symptoms have generally bee mild and of no more than three days' duration. The inci dence in prepubertal children would appear to be les than 1% for reactions that would interfere with norma activity or necessitate medical attention.

How Supplied: Single-dose vials of lyophilized vaccine containing when reconstituted not less than 1,000 $TCID_{50}$ (tissue culture infectious doses) of measles virus vac cine, live, attenuated, 5,000 $TCID_{50}$ of mumps virus vaccine, live, and 1,000 $TCID_{50}$ of rubella virus vaccine, live expressed in terms of the assigned titer of the FDA Reference Measles, Mumps, and Rubella Viruses, and approximately 25 mcg neomycin, with a disposable syringe containing diluent and fitted with a 25-gauge, ⅝" needle. Also in boxes of 10 single-dose vials nested in a pop-out tray with a separate box of 10 diluent-containing syringes.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

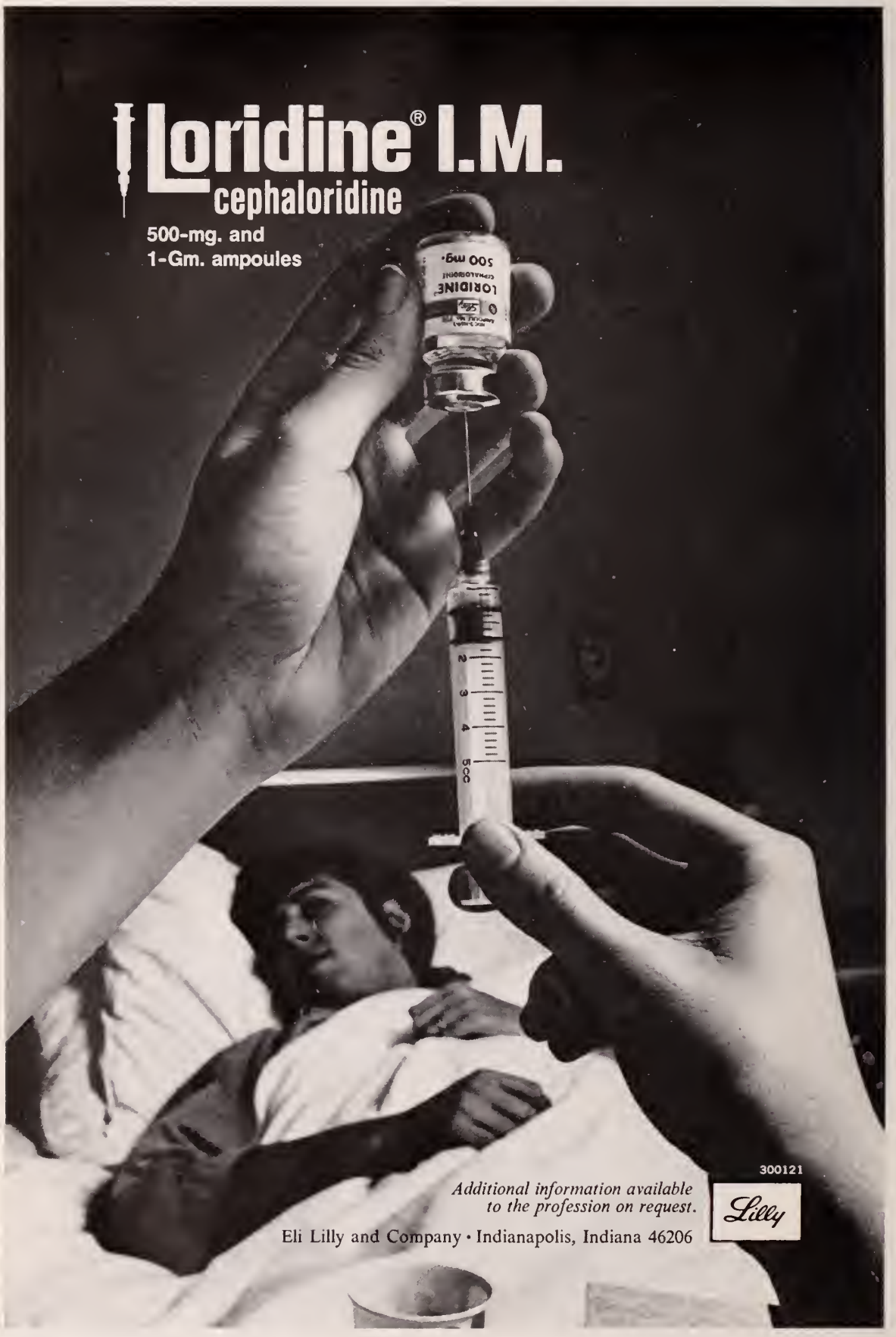
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EDITORIALS

Our New Editor



On August 23rd, our Society, and *The Journal* especially, suffered a grave loss, with the death that day of Henry A. Davidson, M.D., our Editor for 32 years. Finding a replacement was no easy task; he was a "hard act to follow."

In Arthur Krosnick, M.D., our new Editor, we have found a worthy successor. Born and educated in Trenton, he received his A.B. (1944) and his M.D. (1950) from Temple University, with time out for service in the Navy. After internship in Mercer Hospital (Trenton) and residencies at Presbyterian—University of Pennsylvania Medical Center and the Graduate Hospital of the University of Pennsylvania, he returned to Trenton to practice internal medicine and was board certified in that specialty in 1957. His primary interest has been in diabetes, and he has authored over fifty papers, pamphlets, and articles on the subject. In addition, he has written programed learning courses for patients and doctors, and made tapes on diabetes for the "Medical Tapes by Phone" program.

Dr. Krosnick has many talents and great enthusiasm. We welcome him to our *Journal*, secure in the knowledge that our future is in good hands.

Daniel B. Roth, M.D., Chairman
Committee on Publication

Individual Health Education: The Role of the Physician

In a special article in this issue (page 943), the author concisely describes a pioneering community health education project in one of New Jersey's medical centers, and refers to other examples elsewhere in this nation. The range of subjects—diabetes, venereal disease, obstetrics, baby-sitting, alcoholism, and coronary heart disease—merely scratches the surface of potential topics. Like group psychotherapy, the methods described tend to be economical of time and effort and lend themselves to the use of multi-media educational techniques. The use of a pre- and post-test, to evaluate increments of learning and, presumably, change in behavior in self-management procedures, is a commendable evaluatory tool.

The team members of the faculty in community education comprise physicians, in conjunction with other professionals and nonprofessionals, including nurses, nutritionists, social workers, and college students. The author also points out that the patient himself has a definite role in the teaching-learning process and, in fact, the most important one of all.

Commendable as the group or community approach to health education may be, it cannot replace that technique which is quantitatively much greater—that is, individual health education. If we keep in mind that every

physician-patient confrontation can or should be an educational experience, then the point is quite clear. Like it or not, we "educate" our patients, both positively and negatively by word and deed, by body language, by inflections, facial and verbal expressions, and by omissions. The obese physician who is trying to instruct his patient on a calorie-restricted diet may be undermining his own efforts as surely as the practitioner who is smoking while he advises his patient to do otherwise! Communication is the essential ingredient if an educational experience between the teacher (physician) and student (patient) is to succeed. Since the surgeon knows far more about his proposed operation than the patient, the gastroenterologist is a greater expert in colostomy care, and the physiatrist can best instruct the stroke patient on his rehabilitative regimen, it follows that other physicians can teach easily and well, with little effort or time. If we express ourselves in terms the patient can understand, regularly check our effectiveness by a technique of feed-back, and consistently reinforce our efforts to educate—to change behavior—by careful repetition and appropriate praise, we can make every patient contact an effective educational experience. A.K.

Emotional Effects of Isolation

A biochemical explanation for some varieties of drug addiction, criminal behavior, and psychotic behavior has been developed at Indiana University. Their work indicates that social isolation—the absence of physical and emotional contacts with other members of the group—profoundly changes the biochemistry of the brain and nervous system. Social isolation significantly lowers the nervous system's capacity to produce chemical inhibitors that, among other functions, suppress antisocial and psychotic behavior. Social isolation significantly increases the behavioral and chemical reactions to amphetamine. The isolated laboratory animals get "higher" faster.

Dr. Francis V. DeFeudis, Assistant Professor of Psychiatry and Pharmacology at the medical school, has taken these results from his experiments with large populations of genetically identical mice. "We have not yet done the experiments which would confirm our findings in humans, but the apparent analogies to human behavior are overwhelming. We will be quite surprised if these results are not confirmed."

In the experiments, mice were picked at random from laboratory colonies and placed in isolated cages. They were well fed and watered, but they had no contact with other mice. Classic symptoms of depression, in both behavior and biochemistry, developed. As an example, the brains of the isolated mice lost much of their capacities to metabolize glucose and mannose. When isolated mice were returned to their colonies, the biochemistry of the brain and nervous system worked back to normal levels.

"These were highly significant results," Dr. DeFeudis commented. "They showed that profound and prolonged changes in the social environment produce real, measurable changes in the physiology and biochemistry of the brain and nervous system. There were also some behavioral changes. The mice that came back from isolation reacted violently and aggressively to their renewed social contacts.

"They would attack without provocation," the investigator said, "and their attacks—in mouse terms—were irrational. They were not fighting for food or water or space in the cage. They were fighting to kill . . . The chemicals which act in the nervous system to suppress abnormal behavior simply were not getting into the system in sufficient quantity."

These results have an immediate application to man, Dr. DeFeudis continued. "This shows how truly stupid it is to punish prisoners by throwing them into isolation. If their problem is aggressive and antisocial behavior, then isolation will only aggravate the behavior."

___ H.A.D.

—From the March 7, 1973 *Medical Tribune*

ORIGINAL ARTICLES

A lot of medical teamwork is required in this kind of effective prehospital care.

Physicians' Involvement In Emergency Medical Care*

William A. Dwyer, M.D./Paterson

First aid has traditionally included four elements of initial treatment:

1. Simple airway clearance and artificial respiration if indicated
2. Control of external hemorrhage by pressure bandage or tourniquet
3. Splinting of real or presumed fractures
4. Safe, rapid transport of the sick or injured patient.

In the recent past, the technic of cardiac massage has been evolved and added to these first aid "basics." It has also become increasingly clear that these so-called "hands only" technics are not completely adequate for the early care of the heart attack victim. The finding of potentially fatal, but correctible, cardiac arrhythmias occurring in the first few hours after onset of a myocardial infarction has brought about the development of two approaches to the solution of this therapeutic problem.

The first is the mobile coronary care unit manned by physicians and nurses as exemplified by the cardiac ambulances run in this area by St. Vincent's hospital in New York and Martland Medical Center in Newark.

The other is the "communications approach." All ambulances in a given area are equipped with two-way radios connecting them to hospital emergency rooms and/or to physician-consultants. This radio is capable of transmitting patient electro-cardiograms and allowing two-way conversation between the physician and technicians aboard the ambulance. The physician interprets the cardiogram and instructs the technician as to remedial steps to be taken as indicated by the patient's condition. These technicians, of course, must be specifically trained in the technics of starting intravenous fluids, of administering specific intravenous medications, and of defibrillating a patient with electric current.

The advantage of this latter approach is the increased rapidity of response, economies of operation, and accessibility to patients as contrasted to the much more expensive single unit cardiac ambulance. It is currently being employed in several areas, notably Miami, Jacksonville, Los Angeles, and Nassau County on Long Island, among others.

Allowing ambulance technicians to start intravenous fluids has long been resisted by the medical and nursing professions and by first aiders themselves. Nevertheless, this has been a standard practice in the Armed Forces since World War II and has resulted in the saving of many lives in military situations. Its application to our highway casualties has been due for some time and its use in the emergent care of myocardial infarct victims is a further ex-

*From the Department of Surgery, St. Joseph's Hospital, Paterson, New Jersey.

ample of the need for this modality in pre-hospital care of patients.

Mouth-to-Mouth or Ambu-bag resuscitation is carried out now where indicated pretty much as a matter of routine by ambulance technicians. This is coupled with normal clearance of the airway. Many surgeons and anesthesiologists, however, feel that a better answer would be the institution of endotracheal intubation in patients requiring such care. The technics of starting intravenous fluids and intubating tracheas are not taught in any Red Cross First Aid course. Neither is the technic of cardio-pulmonary resuscitation, nor is there anything in such courses relative to the delivery of a baby.

Already, community colleges in this state are preparing 80-hour instructional courses which will upgrade the medical educational level of ambulance technicians and prepare them for the advanced courses in the technics of intravenous fluid therapy, coronary care, and so on.

Additionally, in this state, a more coordinated emergency call response for given local areas is being developed. Already, the Muhlenberg and Valley Hospital areas have installed radios in the ambulances and the Emergency Rooms linking them together. Most of Passaic County is in the process of installing, or has installed, similar equipment, as has Burlington County, and a number of other areas are actively engaged in applying for money for the necessary equipment. New York, Los Angeles, and other large metropolitan areas are already providing interesting data on the 911 "call for assistance" type of program.

In short, the first aid field is developing an entirely different concept of initial care and transport, made possible by the advent of more sophisticated communications' equipment and the newer developments in medical knowledge. The basic thrust of this concept is the initiation of an in-hospital type of care under physician supervision by specifically trained ambulance technicians at the patient's initial location when detected.

The hardware for this type of care is already being installed, the communications frequencies have been allocated by the FCC, the technicians are beginning their training, and the pilot area studies have been completed. Results coming from these pilot areas leave little doubt of the value of such programs.

Stimulated by the improvements in survival obtained on in-hospital coronary care units, the first efforts concentrated on developing similar mobile units. The first of these appeared in Belfast, Ireland. Reporting on their experience with this unit, Partridge and Geddes[1] noted successful resuscitation of 25 patients and were able to transport all patients handled (312 in a fifteen-month period) without loss of life. This contrasted with 102 deaths out of 414 such patients transported in a one-year period prior to instituting such care.

Utilizing the "communications" approach, in Jacksonville, of 505 heart attack victims, 88 required cardio-pulmonary resuscitation with only 11 reported as DOA on arrival at the E. R. (reporting period was six months); in Atlanta, after a pre-hospital coronary care program was instituted at the stadium, eleven definite cases of coronary occlusion requiring CPR were cared for, of whom five were discharged from the hospital living and well following treatment for their occlusion; in Nassau County, in the first few months of operation, 1,300 cases were handled. Of these, 234 presented with chest pain, 25 were dead when the ambulance arrived (average response time was 6.8 minutes), 28 patients worsened during transport (these technicians could start IV's and defibrillate, but not administer drugs), and 18 were resuscitated.

It is obvious that the medical profession which is largely geared to thinking in terms of acting after a patient actively seeks help from the physician must reorient itself to this newer treatment modality.

While at first glance, this may not seem like much of a problem, closer inspection will reveal that it will take some expertise in the

fields of both traumatic surgery and cardiology in order properly to supervise ambulance technicians by radio. Additionally, this will mean a 24-hour a day commitment to this task. Finally, the number of emergency rooms capable of rendering such service will have to be limited just on a personnel basis alone, much less on an economic basis.

This concept of extending the E. R. to the patient poses a new challenge to the medical profession that it must face soon. Physicians will be needed both to teach in these courses and in the E. R. and also to act as supervisors for these programs, perhaps in the emergency room, perhaps from their own office or the coronary unit of a hospital.

Each local area will have to work out the physician coverage arrangement best suited for its own unique needs. For rural counties, each physician rotating the coverage of the emergency service in turn may be the best answer. For more urban areas with larger volumes of patients, it should be obvious that a number of physicians will have to be involved exclusively in this type of service. Perhaps, in this latter instance, an incorporated group of such physicians may be the answer. Hospitals themselves will have to decide which of them will take on the responsibility for acting as the recipient institution for emergency cases in each area. No commissar or health department commissioner can make these decisions for any particular area. The county medical societies can and should be acting as catalysts for their own members, with the active encouragement and guidance of the state society.

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St. Joseph's Hospital

New Method for Female Sterilization

The widely-publicized "Band-Aid surgery" for female sterilization may give way in the future to a procedure that doesn't even require a small bandage, since no incision is made.

The new method is called hysteroscopy, and takes only three or four minutes to perform, said a recent report in the Medical News section of *JAMA*. The patient recovers within hours so the technique has potential as an outpatient or office procedure.

In laparoscopy, or "Band-Aid surgery," two very small incisions are made in the patient's abdomen to admit a viewing instrument and a probe which the surgeon uses to sever the Fallopian tubes (which carry eggs from the ovaries to the uterus). In hysteroscopy, the physician distends the uterus and inserts a fiberoptic "telescope" to visualize the tubes and direct the probe.

Initially, the new procedure was conducted in the operating room, said Dr. Robert S. Neuwirth of Columbia University College of Physicians and Surgeons. Later, patients were treated as outpatients and allowed to go home after a 2 to 4 hour recovery period. Dr. Luis A. Cibils, professor of obstetrics and gynecology at the University of Chicago Pritzker School of Medicine, commented that hysteroscopy is "the method of the future."

Handling a carcinoma of the lids or orbit is a delicate bit of ophthalmic surgery. How do they do it? Here's how!

Treatment of Carcinoma of the Lids and Orbit*

Gerard M. Shannon, M.D./Philadelphia

Among the ways of treating carcinoma of the lid and orbit, the first is completely to excise or remove the malignancy. A second aim is to effect the best possible cosmetic result. These must be considered in this order. No consideration of repair should be entertained until the tumor is removed.

Basal cell carcinoma occurs in the male only five per cent more frequently than it does in the female. Certain important precipitating factors include mechanical, thermal, and chemical carcinogens. Other factors to be considered are hygiene, chronic infection, and irradiation. Outside exposure and a history of previous carcinoma on the skin must be considered. Most series indicate the commonest site is the lower eyelid, next the inner canthus, with the upper lid and outer canthus being involved less frequently. Individuals more prone to this condition are the blonde light-complexioned blue-eyed persons who get a fair amount of sun.

To establish the diagnosis, we have chiefly utilized two methods. If the lesion is on the lid margin then a shaving procedure is carried out. If the lesion is located elsewhere, we use a three millimeter trephine which makes a specimen with a good core. Multiple specimens are usually taken. This must be indicated on a topographical map so that the pathologist and the surgeon may correlate their study.

Four factors involve what type of surgery is to be done:

1. tumor—biopsy, diagnosis, size, location
2. age and general condition
3. skin elasticity
4. the binocular or monocular patient.

Simple excision in the area of the medial canthus can be effected quite easily. Many times, no suturing is needed. Care, of course, must be exercised so that the canaliculi are not injured. Z-Plasty or a free skin graft (when the lid margin is not involved) can be used with an efficacious effect.

Lid Tumors: When full thickness lid is involved, we have recently used direct approximations to effect closure. The figure of eight as an older procedure has been very useful and is a rather rapid procedure. The pentagon repair which includes the three sutures at the lid margin has been utilized recently. Care must be used to effect a solid closure of the tarsal plate and orbicularis below the lid margin so that a satisfactory result can be anticipated. When the lesion involved is three to five millimeters, the pentagon excision is usually adequate. When the lesion is larger than this, and sometimes up to approximately one half of the lid, then mobilizing the lid by doing a canthotomy and then releasing the inferior or superior crux of the lateral canthal tendon (cantholysis) will allow the lid to be rotated towards the defect so that the tension may be relieved and a good result produced.

*Read before Section on Ophthalmology, 207th Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 13, 1973. Doctor Shannon is Clinical Professor of Ophthalmology, Temple University School of Medicine, and Director and Attending Surgeon, Oculoplastic Department, Wills Eye Hospital, Philadelphia.

When the amount of the lid is greater than half to the entire lid, then the Hughes or a lid-sharing procedure has given us our best results. This uses the tarsal plate from the opposite lid as the inner layer of the reconstruction and skin which can be obtained from the same lid as a sliding flap. A free skin graft can also be used to form the outer portion of the reconstruction. This union should be allowed to remain in place for six to eight weeks before section and allowing the lids to open. Care must be exercised on the donor side so that no skin remains attached to the inside of the lid which would produce irritation of the globe and the cornea. This procedure can be used well both at the medial and lateral canthus as long as a periosteal flap is used to achieve the tarsal graft. When large defects must be removed of not only lid, but facial skin, two methods are used for repair. One method is to utilize the split thickness graft which can be obtained by the use of a dermatome. The other is a large flap which has been suggested by Mustarde.[1] The flap technic (which can produce excellent results) requires rotation of large skin flaps. For this reason, skin grafting has been more popular from behind the ear or the supraclavicular area. Alternatively, one can obtain a free dermatome graft from the thigh of the patient.

In dealing with tumors of the orbit, four major avenues of treatment are considered:

1. Orbitotomy
2. Exenteration
3. Radiation
4. Chemo-therapy

First, consider the anterior approach of the orbitotomy. The anterior approach may include a skin incision; three millimeters from the lash line throughout its entire length, and then a deeper incision down at the orbital bony margin entering the orbit from below. This skin incision may also be made down at the area of the periosteal incision as a variation. Another approach is *via* the superior brow where an incision is made in the brow line. The incision is carried down to the periosteum and this is reflected to enter the orbit from above. Should the orbitotomy be in the region of the trochlea then the bone surrounding the trochlea should be carefully chiseled, removed, and replaced after surgery to prevent diplopia which can result from disturbing the superior oblique muscle. The lacrimal orbitotomy, or Kroelein procedure,[2] includes a horizontal incision at the lateral canthus. This incision extends into the upper and lower lids and the skin, orbicularis, and fascia are retracted so that the bony margin can be exposed. The periosteum is incised and the bone is cut using a Strycker saw creating a lateral flap so that the retrobulbar space is exposed. This procedure requires great care. There should be considerable consultation with the patient, and the family, about the possibility of decreased visual acuity or decreased function of any of the extra-ocular muscles, including the levator, following this type of surgery. Should carcinoma extend to the orbit, it arises from three main avenues. One is direct extension from a carcinoma of the lid or the area surrounding the lid. Second, through the metastatic route, for example, metastasis from breast cancer. Third, from the surrounding tissues such as the sinuses and lacrimal apparatus. When the tumor is extensive, exenteration is indicated. This may be accomplished by an immediate skin graft or the orbit may be allowed to fill with granulation tissue and a secondary skin graft applied. The latter approach is certainly indicated where there is some question about whether or not all the tumor has been excised. The tumor if present in the orbit because of extension from the lacrimal gland would, of course, require evaluation for just how much surgery is indicated. Tumors of the canaliculus and sac usually require complete excision because of local recurrence. The pathologist will be helpful in determining which procedure would be efficacious. If the tumor is present in the orbit as a result of metastasis, the patient will not only require surgery to establish the diagnosis (possibly even exenteration to remove an unsightly mass) but also the combined efforts of the radio-therapist and chemo-therapist to manage the case. This may indeed be only palliative.

In conclusion, I would like to suggest early diagnosis and early excision. Secondarily, reconstruction of the defect that is produced by the excision should be thoughtful, with the aim of producing function first and cosmesis second.

8118 Bustleton Avenue

Cardiac Risk Factor Intervention Trial

The College of Medicine and Dentistry of New Jersey, New Jersey Medical School, has been awarded a contract by the National Institute of Health to become one of the few centers throughout the nation to engage in research aimed at "well people" who have a high risk for coronary heart disease.

Norman L. Lasser, M.D., Ph.D., Assistant Professor of Medicine and Biochemistry, is the Project Director. Dr. Lasser is also Director of the Center for Coronary Risk Factor Control at CMDNJ-New Jersey Medical School.

Males between the ages of 35 and 54 will be screened for this project, and all must be free of known heart disease yet have in common one or more of the three major risk factors: hypertension, high cholesterol, and a smoking habit. Coronary disease kills more Americans than any other single disease. The three risks mentioned may, in combination, give healthy-appearing persons 3 to 10 times the risk of developing coronary disease as those with none of them, the project director added.

The nation-wide research involving 12,000 patients will seek to determine if modification through treatment of all the major risk factors leads to a decreased risk of developing heart disease. This is the largest single project ever carried out by the National Heart and Lung Institute.

Most deaths from coronary heart disease are outside of a hospital and occur unexpectedly within two hours of onset.

Starting in the spring of 1974, some 15,000 men will be screened for eligibility for the study. Those enrolled in the special intervention group will be examined on a regular basis and have their multiple symptoms treated. Diet alone will be the treatment for high cholesterol problems; hypertension will be treated with drug therapy if necessary. The smoking problem will be tackled through withdrawal programs.

Dr. Michael Gutkin, Chief of the Hypertension Clinic at the Veterans Administration Hospital, East Orange, will head up the hypertension portion of the project while Elizabeth Munves, Ph.D., Director of Nutrition Services at the College, will be director of Nutrition. Dr. Lawrence Hall, Assistant Professor of Psychiatry, will handle the smoking withdrawal portion.

St. Michael's Medical Center (the first community hospital in the nation to establish a department of cardiac surgery and to perform open-heart surgery) will be the major clinical center for the project.

Other clinical facilities to be put into play include the Family Health Care Center, Martland Hospital, and the I.L.A. Medical Center located near the docks for the convenience of longshoremen participating in the project.

Each patient enrolled will get an annual examination, including an electrocardiogram and laboratory tests, without charge. Those in the program will be receiving therapy, including medication, at costs borne by the NIH.

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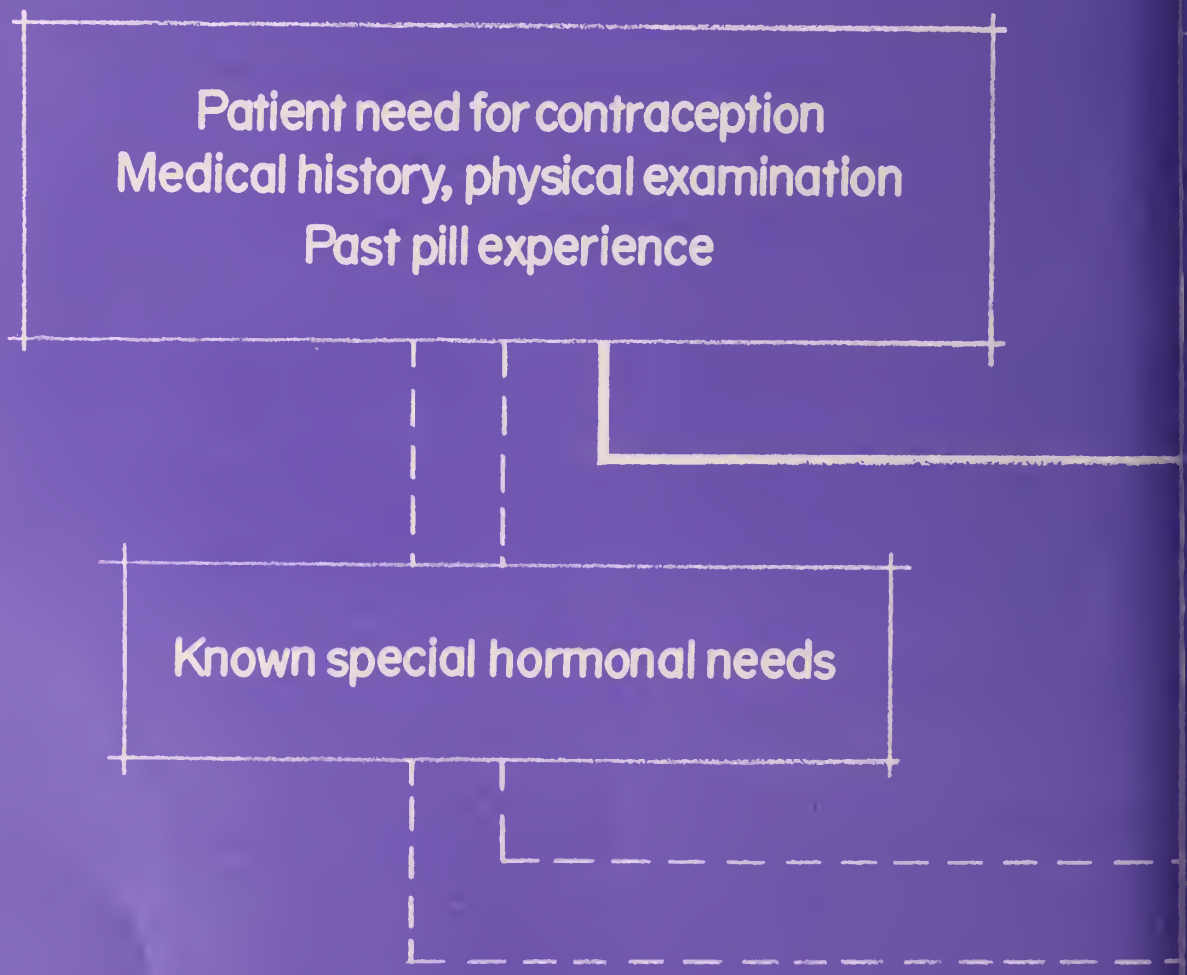
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rimarily on animal studies.

Note: Oral contraceptives are complex medications. As with all medications they should be prescribed with discriminating care, and only after reference to full prescribing information For brief summary of prescribing information, please see next page.

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Each white tablet contains: ethynodiol diacetate 1 mg./ethinyl estradiol 50 mcg.
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Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in the United States. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor such as epilepsy, migraine, asthma, cardiac or renal dysfunction require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

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Indication—Enovid-E is indicated for oral contraception.

The *Special Note, Contraindications, Warnings, Precautions* and *Adverse Reactions* listed above for Ovulen and Demulen are applicable to Enovid-E and should be observed when prescribing Enovid-E.

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Where "The Pill" Began

Although hexachlorophene is a broad-spectrum poison, the presenting signs may be not only neurologic, but also may suggest a focal lesion.

Burn Encephalopathy or Hexachlorophene Poisoning?

Fred A. Mettler, M.D./Blairstown

Recent progress in understanding the effects of toxic substances upon the neural system has shown that, whereas the chemical effects of such materials may be widespread, the clinical symptomatology may be suggestive of sharply localized lesions.[27] Microscopic examination by conventional methods may fail to show any lesions in such cases. Subsequently, when pathophysiology is evident, and obvious morphologic lesions do develop, it becomes possible to explain the initially observed pathophysiology on the basis of interference with the availability of oxygen to regions having vulnerable blood supplies.[28] When obvious lesions have developed the abnormal behavioral patterns may disappear, or become submerged by entirely different types of abnormal function. Recent attention to the concurrence between infantile paraplegia and the apparent transcutaneous* absorption of hexachlorophene emphasize the necessity of being aware of why toxic substances which produce generalized neuropathology may be characterized by a symptomatology of sharply localized type. Since the recent literature on hexachlorophene has tended to focus more upon the issue of regulation of its use, rather than upon its mode of action, it appears desirable to recall that hexachlorophene is a phenolic congener (and that much of the ground now being traversed has been covered before) and that some of the prime uses for which hexachlorophene was developed have long been adequately served by alcohol.

Toxicity of Phenol

After Lister,[22] in 1867, used carbolic acid in popularizing antiseptic surgery, it was soon found that undiluted phenol, so employed, produced obstinate vomiting of about 24 hours' duration. Watery solutions were therefore substituted for washing wounds and as a spray. Lister paid little attention to the toxic effects of the external use of such dilute solutions which could be detected by the greenish darkening of the urine. (Vierordt)[32] but, by 1894, Hamilton and Godkin[14] accepted as commonplace the knowledge that death might be produced by the external application of carbolic acid. This was one of the first substances controlled by the required use of the skull and crossbones label (Hechtlinger).[15] An enormous literature on the biologic effect of phenol leaves no doubt that it is readily absorbed through the skin. In an early conclusive report Brown[6] described unconsciousness occurring in a child within five minutes of massage of unbroken skin with carbolic acid. The nature of the cause was confirmed by the renal disturbance which ensued. Goodman and Gilman[10] recently ratified such observations. "In the past, poisoning frequently re-

*A distinction must be made between the use of the words percutaneous (passage through the unbroken skin) and transcutaneous (passage through skin of which the condition is unspecified). While it is obvious that substances can pass through broken skin much more easily than intact skin no sharp distinction based upon the condition of the skin can easily be made since intact skin which is immature has a different passage rate than a thick and aged hide. Moreover, materials *rubbed* on skin pass at different rates than if inunction is not employed. Passage rate is also affected by morphologic changes in skin (such as ichthyosis) which do not necessarily break it, and also by the presence of surface tension depressants, and a number of other circumstances.

sulted from the wide use of phenol as an antiseptic."

Phenol produces water-electrolyte derangements as a result of which the patient vomits (even though the chemical has been absorbed from the skin) and becomes dyspneic and unconscious. Pulmonary edema often develops, blood pressure and temperature fall, the kidneys are damaged, the production of urine is discolored and reduced, muscular twitching of uremic type develops, protein and blood appear in the urine and acidosis[4] develops. The toxic dose is usually listed as from 125 to 250 mgm per kilogram for an adult but it varies greatly. Among other influencing factors, absorption from the skin depends on the area exposed and nature of the solution. Lucas and Lance[2-4] treated hundreds of cases with 5 per cent carbolic acid compresses, to sterilize skin preoperatively, before they became aware of their toxic effect (as the result of encountering collapses that occurred before surgery was started and were subsequently explained by the obvious renal damage.) Gleason, Gosselin, Hodge, and Smith[8] try to explain this apparently low incidence of serious effects by assuming the existence of an unspecified type of "hypersensitivity" or "idiosyncrasy" to phenol. The absorption of phenol from the stomach is slower than from the intestines.[7] Thus phenol may be more toxic when absorbed from the skin than when taken by mouth. From this it will be perceived that phenol interferes with mammalian physiologic functions in a number of ways. As a result of its effect on the kidneys, disturbances develop in fluids and electrolytes and, consequently, in hydrogen ion concentration, according to the mechanisms outlined in customary texts such as Hill's.

Congeners of Phenol

Halogenation of phenol increases its toxicity and, consequently, antiseptic capacity. The extensive literature on such congeners of phenol may be approached through review articles cited by Goodman and Gilman.[10] Bechhold and Ehrlich (of Salvarsan fame) found that when two phenol rings are combined, the resulting toxicity of the compound is further enhanced. Some of these products, which are in common use as herbicides and wood preservatives (like pentachlorophenol), are especially powerful. Analysis of the urine continues to be of value in the detection of phenolic congeners but ultraviolet spectrophotometry is less subject to ambiguity.

The remainder of this discussion will be limited to hexachlorophene which consists of two phenol rings, with three chlorine atoms attached to each, and linked through a methyl radical. A number of such modifications of phenol have been developed for use as bacteriostatics and fungistatics. Several of the controlling patents (Givaudan Corporation products numbers G4, G5, G11) were issued to William S. Gump. In the case of hexachlorophene (G11) the patent date for *Dihydroxyhexachlorodiphenylmethane and Method of Producing Same* (U.S. Pat. 2,250,480) is 1941. In 1970 the distributor of the generic product was listed in the National Drug Code Directory as C. M. Bundy of Cincinnati. The patent licensee was Givaudan Corporation and the labeller of the proprietary, known as pHisoHex, was Winthrop, a subsidiary of Sterling Drug. As a member of the Givaudan Corporation (New York) Gump has continued active in the commercial promotion of this substance by publication in scientific and trade journals, reports, and books. He stated that 300 mgm per kilogram produced 80 per cent mortality in guinea pigs which would appear to be extraordinarily resistant since the figures given by other investigators for other species, for a LD_{50} range from 67 mgm to 180 mgm per kilogram. Most primary reports on the toxicity of hexachlorophene have come from sources other than Gump and several as a result of efforts to control gastrointestinal parasitic infestation in animals and man. For *Clonorchis sinensis* infestation a single oral dose of 20 mgm per kilogram has been used. Following a number of fatalities after the ingestion of this compound Gump[13] reviewed the subject of toxicity and concluded that the highly poisonous nature of hexachlorophene when taken internally is not a matter of serious concern if it is used externally on

intact skin surfaces (The presence of a mature derma is implied). Essentially the same material is reproduced in Gump and Walter[12] and in Gump.[13] In a subsequent review of this subject Lockhart[23] took the position that Gump's review was inadequate with respect to absorption and came to very different conclusions as to its safety. Lockhart's article[23] documents the situation which formed the background for federal proposals with respect to control of this substance.

The difference between the position taken by Lockhart[23] and Gump[13] is a critical one. During the period of novelty following the introduction of hexachlorophene, Best, Coe, and McMurtrey[5] did not hesitate to propose the abandonment of U. S. P. soap in favor of hexachlorophene-containing soap for the cleansing of burns and open wounds. However, by 1967, Korlof and Winstein[21] had reported signs of central nervous system toxicity in burned patients washed with hexachlorophene. Quadriplegia developed after a lapse of 7 to 10 days and renal damage was one of the effects of the compound. These authors additionally cited a personal communication from a medical officer in military service (Major S. Levine) who had similarly encountered untoward effects in a large burn service. In the same year Smith[30] commented on the danger of using phenol-containing soaps in enemata.

An anonymous additional 1967 adverse report, based upon observations by Larson,[1] indicted hexachlorophene as the cause of convulsions in nine burned children. It was further stated that hexachlorophene had been detected in the cerebrospinal fluid and serum of exposed human beings, and in the brain and liver of animals. Purpose of this article (which is cited as reference 406 in Givaudan Technical Bulletin H-1) was to call the attention of physicians to the now well-documented fact that hexachlorophene is absorbed in burn cases. By 1970, the label of the merchandiser of pHisoHex (Winthrop Laboratories), a trade name for hexachlorophene, read, "When preparations containing hexachlorophene are left in contact with denuded skin (such as extensive wounds or lacerations or severe burns) sufficient hexachlorophene may be absorbed to cause toxic symptoms" . . . "Hexachlorophene is not absorbed in toxic quantities from intact skin." In that year Arena[2] similarly cautioned that hexachlorophene *not* be used as a wet dressing for burns. In the 1963 edition of his book, Arena had stated, "Systemic effects, though unlikely, presumably would resemble those of phenol" (p. 309). The product label for 1973 contains a number of specific warnings designed to prevent absorption through the mucous membranes and conjunctiva (as well as damaged skin), by adequate irrigation if the substance is allowed to come into contact with such surfaces. However, *The Story of G-11* (Hexachlorophene U.S.P.) (1971 Givaudan Number Two) cites a number of investigations which indicate that the alleged high order of effectiveness of hexachlorophene in sterilizing skin requires protracted retention of the chemical upon the skin. From a purely practical point of view, these potentially conflicting considerations, taken in connection with reports questioning the effectiveness of hexachlorophene as a germicide,** deprive the distinction made by Gump,[13] with respect to safety on intact skin and hazard on mucous membranes and injured skin, of much of its relevance. It is further impaired by the observation that persons using hexachlorophene in a daily scrub routine absorb measurable quantities even though they show no evidence of overt poisoning. It is an axiom of toxicology that objective and subjective effects from substances of proven toxicity appear only after the factor of physiologic safety has been exceeded. Not only is a certain proportion of

**The essential problem is that since hexachlorophene is not a germicide, but a bacteriostatic, (it is not without significance that Givaudan employs a neologism, "degerming" action, in its promotions literature) the immediate results achieved by using it for preoperative skin preparation are more a reflection of the scrubbing process than of the chemical reduction of viable bacteria. A critical survey of the problem of the germicidal efficacy of hexachlorophene appears in Lawrence and Block ('68, p. 536) where the surgeon, P. B. Price, has remarked, "Ethyl alcohol is a time-honored skin antiseptic. In proper concentrations I still believe it to be, on the whole, the best one available for general use." Givaudan's *Annotated Bibliography* contains a number of articles which allow one to reach essentially the same conclusion.

toxic material excreted and detoxified in healthy organisms but approximately fifty per cent of critical tissue can be nullified before any measurable physiologic deficit becomes apparent. This principle, the factor of physiologic safety or Meltzer's law[25] has been demonstrated to apply to the neural system as well as to the better known tissues, such as the liver and kidney (Mettler, Finch, Girden, and Culler.[26])

Phenol may be more toxic when absorbed through the skin than when taken by mouth. The reverse is said to be the case for hexachlorophene. The question of exactly how toxic phenolic congeners, such as dichlorophene and hexachlorophene, may be when taken orally was raised by a review of twenty cases of poisoning, including two fatalities, supposedly due to ingestion of hexachlorophene.[29] Both of these substances have also long been suspected of producing dermatitis, especially when coupled with detergents.[3] Some of the literature on cross-sensitivity to related compounds has been reviewed by Gump and Walter.[12] Additional toxic effects on nonneural tissue, such as the production of atrophy in the seminiferous tubule,[31] will not be discussed here.

The Mechanism of Toxicity in Hexachlorophene Poisoning

In a personal communication to the present writer Lockhart says the mechanism of hexachlorophene poisoning is unknown but we have already observed that Arena[2] felt it is reasonable to suppose that its mechanism of toxicity is similar to that of phenol.

In burn patients suffering from unusual symptoms, who have been exposed to hexachlorophene, the blood pressure appears to be elevated rather than depressed as occurs in phenol poisoning but renal damage and acidosis do occur. Since burn patients generally have considerable electrolyte imbalance it is difficult to evaluate apparent disparities. The fact that in some burn patients the period of renal shutdown is closely correlated in time with the exposure to hexachlorophene makes it very probable, as in the case of phenol poisoning, that hexachlorophene produces electrolyte-fluid imbalance secondary to renal damage. Increased intracranial pressure appears to be a fairly frequent phenomenon as are convulsions and paralysis of the extremities occurs. As will be seen below, something more than simple electrolyte imbalance appears to be responsible for these latter phenomena which are often comprised in the vague diagnosis of "burn encephalopathy."

Hexachlorophene damage of cells, including those of plants, is associated with a leakage of intracellular contents. Gump[12] postulated that the cells were killed as a result of surface damage of the cell membrane and it was this that was responsible for cytoplasmic loss. However, as early as 1953 Gould and others[11] had shown that hexachlorophene inhibits cytochrome oxidase. At the present time, hexachlorophene is believed[18] to kill cells by stimulation of degradative intracellular enzymes. Since the release of cytoplasmic materials from bacteria exposed to this substance is not directly related to the killing effect of the drug, rupture of the cell membrane has to be regarded as a secondary phenomenon. The leaking substance is composed of small molecules, probably derived from pre-existing ribonucleic acid and protein, but not from deoxyribonucleic acid.

Experimental evidence provides an explanation for the increased intracranial pressure seen in hexachlorophene poisoning since vacuolization attests to the existence of severe edema.[19] There is reason to believe such hexachlorophene induced-edema is due to direct intracellular damage. Thus, Klatzo[20] found that hexachlorophene-poisoned rats, rabbits, and monkeys all developed a form of cytotoxic edema, with vacuolization of the white matter and thalamic neuropil, during which glucose transport was strikingly elevated without any changes in cerebrovascular permeability. These animals exhibited paraplegia and papilledema, common signs in human poisoning. Such cytotoxic edema may also be seen in areas of ischemic infarction. In such cases it is not necessarily the exclusive result of oxygen deficiency but may be due, to some extent, in

early stages at least, to impairment of the process of removal of waste products, such as lactic acid, because perfusion with saline protects the tissue.[17] That oxygen deficiency is a significant ultimate factor in hexachlorophene poisoning is probable, however, not only because the drug poisons cytochrome oxidase but also because it is obliged to impair blood flow in critical areas as a result of tamponade due to edema. This would appear to be the explanation for the frequent occurrence of predominantly distal types of spinal alpha fiber compression conduction paralysis in children who, as is well known, do not develop maximum space within the vertebral column until about the seventeenth year. Thus although hexachlorophene is a broad spectrum poison the presenting signs may not only be of a neurologic nature but many suggest that one is dealing with a focal lesion, a circumstance which may lead to considerable diagnostic confusion.

Clinical Course and Treatment

Because the most severe aspects of hexachlorophene poisoning are due to physiologic disturbances, such as acidosis and edema, good results are to be expected if prompt efforts to treat these phenomena can be successfully instituted but in cases where edema of the central neural system is severe and persistent, irreversible structural damage can be anticipated. If this does not exceed the factor of physiologic safety a high order of functional recovery may still develop but the biologic reserves of these individuals remain severely depleted. It is a serious error to discount the disabling potential of latent damage. Gleason, Gosselin, Hodge, and Smith[8] attributed the experience of Lucas and Lance[24] to hypersensitivity. However, a more careful reading of the original report suggests that Lucas and Lance's experience was not unusual but the proper explanation for common occurrences which had previously been erroneously attributed to unfortunate surgical results. In view of the recommendations of Best, Coe, and McMurtrey[5] and others of a similar nature, no one can tell how many cases of so-called "burn encephalopathy" may have actually been caused by hexachlorophene. Whenever its normal factor of physiologic safety has been impaired, the neural system is forever after abnormally vulnerable to subsequent insult.

L'Envoi

One cannot help but be struck (a) by the manner in which hexachlorophene came to displace alcohol as a germicide and (b) the irrelevance of much of the testimony with respect to handwashing as this relates to practical surgical problems. After concluding that alcohol is still the best germicide, especially for preparing the operating site and the surgeon's hands and sterilizing cutting instruments, Price** puzzled about why it has practically disappeared from use. The answer to this is, I believe, a combination of the effect of governmental regulations upon the mindless bureaucracy of institutions and of the effort to blame the results of poor surgical skill upon preoperative contamination. The paper work and special measures required to obtain and maintain a supply of alcohol, to store it and to use it as freely as other reagents, and still restrain diversion, requires a determined frame of reference which is firmly autocratic and still essentially intelligent. I can vouch for Price's endorsement of its utility. For over forty years, I have maintained an experimental neurosurgical laboratory which employs unusually vulnerable complex instrumentation for purposes of deep neurosurgery on "chronic" monkeys (which is to say subjects not merely susceptible to infections but devoid of any detectable concept of personal hygiene, howsoever primitive, and who additionally, are inhabited by a variety of guests as well as uncooperative instincts). Despite this, I have not had a single infection in over 4000 operations, in the last 30 years, with the exception of an occasional stitch abscess. Since the animals are able to pull at the suture line with very busy and not precisely clean fingers, such occasional incidents are hardly surprising. Not only has alcohol been relied upon for sterilizing instruments, briefly rinsing the hands of the operators, and sponging of the operative site but it has never been considered advisable to use any prophylactic antibiotics. The keys to aseptic surgery are not to be

found in a sink ritual nor in any chemical to grant absolution for lapses of diligence and intelligence. Success depends upon complete and vigilant control of the care situation, from the proper selection of cases to the time the stitches are removed. The greatest threat to this is the parcellation of responsibility.

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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

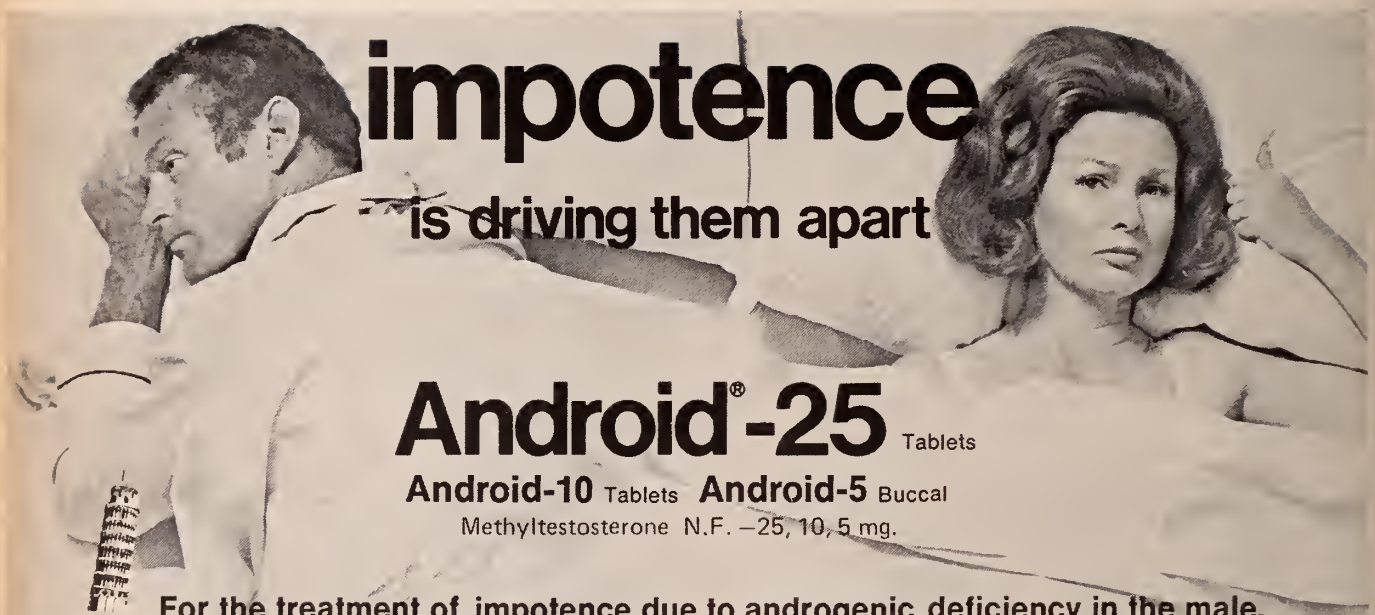
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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To the meager list of reported cases of abscess formation in myocardial infarction, Dr. Vianna and his team add another case.

Myocardial Abscess and Infarction

Report of a Case and Review of the Literature

Nicholas J. Vianna, M.D./Newark*

Abscess formation in myocardial infarct is rare.[1,2] In five previously reported cases, the implicated microorganisms were: coagulase positive Staphylococcus aureus (2 patients), *Streptococcus faecalis* (one patient), *Diplococcus pneumonia* (one patient), and *Clostridium perfringens* (one patient) [3 to 6]. This report describes a patient who developed a Bacteroides abscess complicating an acute myocardial infarction and reviews the clinical features of previously reported cases.

A 55-year-old man was admitted to the hospital with dry gangrene of the left big toe. He had a 15-year history of diabetes mellitus, arteriosclerotic cardiovascular disease with intermittent episodes of left bundle branch block and generalized peripheral arterial vascular insufficiency.

On admission, he had a regular pulse of 85 per minute, blood pressure 110/75 and a rectal temperature of 99. The heart was enlarged to percussion. On auscultation the heart sounds were normal and there were no murmurs. Rales were heard at the bases of both lung fields. The femoral, popliteal, and dorsalis pedis pulses in both legs were reduced, especially on the left. Remainder of the physical examination was negative.

Admission laboratory studies included a hematocrit of 41 per cent and a white blood cell count of 7,900, the differential count showing 80 per cent neutrophils. Urinalysis revealed a specific gravity of 1.015 with moderate glycosuria. Blood urea nitrogen was 27; serum creatinine 1.2, but blood sugar was 335. Electrolytes and liver function studies were within normal limits. Electrocardiogram showed normal sinus rhythm with a rate of 85 per minute and complete left bundle branch block. Chest x-ray revealed only an enlarged left ventricle.

Fourteen days after admission, he developed severe precordial pain and became moderately cyanotic. Serial electrocardiograms and serum enzyme determinations were consistent with an acute posterior myocardial infarct. On the sixteenth hospital day, his temperature (which had never previously exceeded 100), rose to 103, and he experienced several chills. Two days later, a right-sided basilar infiltrate and moderate pleural effusion were noted on chest x-ray. A diagnostic thoracentesis revealed 100,000 cells per mm^3 with 94 per cent neutrophils. Three blood cultures and pleural effusion cultures all showed a strain of bacteroides. He was given parenteral chloramphenicol, 750 milligrams every six hours, to which the organism was sensitive *in vitro*. Subsequent blood culltures revealed a similar organism. The patient died on the twenty-sixth hospital day.

Post mortem examination, 6 hours after death, revealed generalized arteriosclerosis, diffuse narrowing of all coronary arteries with atheroma formation and complete occlusion of the right main-stem coronary artery; myocardial infarction, involving the posterior (inferior) wall of the left ventricle within which was a 2 by 2 cm. solitary abscess; pulmonary edema, bilateral and diffuse; bronchopneumonic infiltrate in right lower lobe with 750 ml of empyema fluid. Microscopic examination of the involved portions of the myocardium disclosed changes consistent with a recent myocardial infarction and abscess formation. Histologic study of the thrombus in the right-main coronary artery indicated that it did *not* serve as the source of infection. No other abscesses were found in the other organ systems. Postmortem cultures from the infarcted-abscess area, the empyema fluid, and the blood yielded bacteroides.

The incidence of primary abscess formation of the myocardium (in the absence of myocardial infarction) is quite low, but appears to have risen in recent years.[2] Thus Flaxman[7] found the incidence to be 0.20 per cent of all autopsies done at Cook County Hospital from 1929 to 1942. Sanson, *et al.*[2], reported a similar incidence (0.24 per cent) at Mount Sinai Hospital, Chicago from 1942 to 1954, but a much higher incidence (1.52

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REPORTED CASES OF ABSCESS COMPLICATING MYOCARDIAL INFARCTION

Source	Patients Age	Sex	Presenting Complaint	Underlying Diseases	Duration from onset to Death	Causative Organism and Probable Origin of Infection
Cossio *et al.*	64	M	chest pain	generalized arteriosclerosis; 2 year history of coronary heart disease	18 days	D. pneumonia, pneumonia meningitis and sepsis
Tedeschi *et al.*	69	F	comatose	generalized arteriosclerosis; hypertension	7 days	S. aureus, coagulase positive; pneumonia and sepsis
	75	M	chest pain	generalized arteriosclerosis; hypertension	4 days	S. aureus, coagulase positive; pneumonia and sepsis
Tennant *et al.*	67	F	comatose	Diabetes mellitus — 12 years; previous myocardial infarct	less than one day	Clostridium perfringens; chronic cholecystitis
Miller *et al.*	76	M	comatose	generalized arteriosclerosis; recurrent urinary tract infection	4 weeks	Str. faecalis; acute pyelonephritis

per cent) from 1955 to 1961 in the same institution.[2] Judging by the paucity of reports, abscess complicating an acute myocardial infarction is even more unusual. Other than rapid clinical deterioration in the setting of a myocardial infarction, there appear to be no distinguishing clinical or electrocardiographic features of this complication. The present and previously reported cases do however have a number of features in common. All six patients were elderly and four of the six were males. All had severe arteriosclerosis (5 of the 6 generalized) and the present case plus that reported by Tennant, *et al.*[5] had long-standing, adult onset diabetes. Duration from onset of acute illness to death (an apparently inevitable result of this complication) appears to be relatively short in most instances, ranging from probably less than 24 hours to, at most, four weeks. Staphylococcus aureus, the most common etiologic agent in primary (non-infarcted) myocardial abscess complicated myocardial infarction in two cases.[4] However, a wide variety of aerobic and anaerobic organisms are capable of causing either primary or post infarction myocardial abscesses. Although pneumonia appears to be the most common initial source of infection (as was probably true in the case herein reported), it is likely that any primary focus causing sepsis can result in this complication.[1 to 7] Furthermore, as suggested by the case report of Tennant and Parks,[5] overwhelming sepsis is not an essential prerequisite. In addition to circulatory collapse, a result of either the myocardial infarction or the sepsis, (or a combination of the two), death may result from sudden myocardial perforation, a complication which occurred in two of the six cases reported.[4,5] In contrast, perforation occurs in only about 10 per cent of the reported cases of primary myocardial abscesses.[2] Although the number of cases reviewed is too limited to permit any firm conclusions, the similarities in the six cases reviewed suggest a rather characteristic setting and course for this unusual complication of myocardial infarction.

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100 Bergen Street

An unusual suggestion for preventing immunological rejection is here offered.

Prevention of Rejection Reaction Without General Immunosuppression

Alexander Strelinger, M.D./Elizabeth

In 1966, in the discussion part of a paper on heterokaryons, Henry Harris,[1] stated:

"Perhaps the most important conclusion to be drawn from these experiments is the fact that cells from different species of vertebrates are compatible with each other when they are fused together into a single unit. This is true for highly specialized cells and even for cells capable of mounting an immune response to a foreign antigen. It thus appears that in the somatic cells of vertebrates there are no intracellular incompatibility systems comparable to those which determine histocompatibility in different individuals."

Though Harris did not spell it out, the concept for prevention of the rejection reaction lurks in this discussion.

In 1971, this statement unbeknown to me, I suggested a hypothesis[2] for prevention of the rejection reaction. The suggestion was that such prevention may be achieved by bringing about the coexistence of the genetic masses of both the donor and the recipient in one cell. The underlying thought is that coexistence of the genetic masses in one cell may prevent coding for antibodies. As an example of the possibility of such coexistence in one cell, having had no knowledge of Harris' statement at that time, I quoted the hybrid cells.

As it does not seem at present to be within the realm of the most overdimensioned imagination to fuse cells of a living donor with cells of a living recipient, as an equivalent, for the purpose of prevention of the rejection reaction I suggested the introduction of donor DNA, the donor genetic material, into the cells of the recipient. The DNA/cell hybrid created by introduction of the donor genetic mass into the recipient cell may duplicate the intracellular climate of heterokaryions or cell/cell hybrids. Then, there would be no intracellular incompatibility, thus preventing the rejection reaction.

There are reports in the literature on introduction of mammalian DNA into mammalian cells. Transfer of various genetic markers was achieved by transfer of DNA. But the rate of successful transfer of mammalian DNA into mammalian cells is so far pitifully low. While Koprowski[3] considered my suggestion for prevention of the rejection reaction "not unreasonable," Krooth[4] commented: "Hence, although I think what you suggest may eventually come to pass, I regard it as prospect for the remote future."

Niu[5 to 9] had success in modifying various cells by introduction of RNA. He[10] feels that perhaps mammalian donor RNA may be introduced successfully into mammalian recipient cells and reverse transcriptase may be relied upon to back-code donor DNA in the recipient cells.

Harris[11] succeeded in fusing lymphocytes of two different vertebrates.

Supposing that Niu's suggestion may be successful the following may be an experimental protocol:

"A" is the donor mouse. "B" is the recipient mouse. They should be immunologically incompatible. Isolate $_{m}$RNA from A and introduce it into a lymphocyte culture of B. Harvest A lymphocytes and also B lymphocytes modified by A $_{m}$RNA. Fragment B lymphocytes in a bomb. Set up A lymphocytes and fragmented modified B lymphocytes as a mixed lymphocyte culture. The fragments of B lymphocytes, not being whole cells, will not be stimulated by A lymphocytes. If A lymphocytes will not be stimulated by B lymphocyte fragments, as they would be otherwise by an incompatible lymphocyte, that would evidence that modification of the B lymphocytes by introduction of $_{m}$RNA of A cells made the B lymphocytes compatible with A lymphocytes.

Various other technics, already used and previously reported may be made to create DNA/cell hybrids. Some of these methods include encapsidation, fusion by viruses, and fusion by lysolecithin.

It remains to be seen whether this hypothesis works. However, if it does work, the rejection reaction of a recipient against a specific donor may be obviated; and this without the dangers of the present repression of the rejection reaction: repression of the immune reactions of the recipient against infections and predisposition to malignancies arising in the recipient.

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220 West Jersey Street

Calcium-Utilization and Requirement

In general, the body can adapt to varying calcium intakes by regulating the intestinal absorption and renal excretion of calcium. A number of factors influence calcium absorption, although the mechanisms are not clearly understood. Vitamin D is by far the most important exogenous factor affecting calcium absorption. The vitamin D metabolite, 1,25-dihydroxycholecalciferol, is recognized as the "hormonal form" of vitamin D responsible for the maintenance of serum calcium; it may also be involved in the synthesis of an intestinal calcium-binding protein. The extent to which this vitamin D-induced calcium-binding protein participates in calcium mobilization is a matter for speculation. The effect of both dietary phosphorus and the dietary ratio of calcium-to-phosphorus on calcium utilization is not firmly established. Dietary protein is directly correlated with urinary calcium excretion, although the long-term effect of protein on calcium retention remains to be determined. In the presence of lactose, calcium absorption is increased. The interactions of phosphorus, magnesium, fat, oxalic acid, and phytic acid with calcium are discussed. The above nutrient interrelationships and the reports of increased calcium needs for those individuals predisposed to osteoporosis and those who do not readily adapt to varying calcium intakes should not be overlooked in the consideration of the optimal intake of calcium. It is obvious that there are considerable gaps in our information on the metabolism of calcium. Research on many areas of calcium metabolism, in particular the interrelationship of calcium with other nutrients, is a necessity.

Dairy Council Digest, 44:25, 1973

Practitioners sometimes forget that a knowledge of anatomy is basic to all clinical practice. Here is an example.

Applied Anatomical Aspects of Pain*

Harry A. Kaplan, M.D./Newark*

In any consideration of the problem of pain one needs a clear concept of the organization of the nervous system *in toto:* central, peripheral, and autonomic. The location of the pain, its distribution, the probable neural pathways over which the pain impulses are likely to be mediated, and the individual's interpretation of its character and severity. Stimulation of an exposed peripheral nerve and/or a sizable artery produces a sensation usually interpreted as pain. Excessive stimulation of some receptors may be interpreted as pain; for example, touching a hot surface, a flash of intense light, or a loud noise. A pathologic lesion near (or directly involving) receptors as, for instance, a glomus tumor under the nail bed or a trigger zone occasionally found in the pox secondary to herpes zoster frequently produces a sensation interpreted as pain. From all these pain receptors, impulses are transmitted over sensory nerve fibers. These fibers are believed to be those of the smaller medullated variety as well as the unmyelinated C fibers. The medullated fibers in visceral nerves are called B fibers. Clinical syndromes of pain secondary to compression of a peripheral nerve are seen in the carpal tunnel syndrome or with other nerve entrapments. Partial physiologic interruption of a peripheral nerve may result in causalgia. The red, swollen, and highly sensitive part distal to the area of a traumatized nerve is a familiar observation. Visceral fibers carrying pain impulses apparently are no different from the somatic fiber except that they have a more sparse distribution. Viscera are insensitive to many mechanical and chemical stimuli. Yet, severe pain may be experienced when a gut is distended or when it is in spasm.

Both somatic and visceral pain fibers enter the central nervous system through the dorsal spinal roots and synapse in the dorsolateral fasciculus of Lissauer and in the substantial gelatinosa of Rolandi. Receptor nuclei for somatic and visceral pain impulses are integrated in the dorsal gray column of the spinal cord. This is also the probable mechanism for referred pain. For example, in appendicitis one occasionally may demonstrate a zone of hyperalgesia of the eleventh thoracic segment. An internuncial pool of neurones within the spinal cord is thought to be a part of the sensory receptive mechanism. Abnormal firing patterns in closed self-exciting neurone loops within these neurone pools have been regarded by Livingston[1] and Gerard[2] to be the basis for the pathophysiologic states producing pain secondary to injury of a limb. Melzack and Wall[3] proposed a "gate-control" theory of pain. They stated that a portion of the brain stem reticular formation exerts a tonic inhibitory influence on transmission at all synaptic levels of the somatic projection system. When a large proportion of sensory fibers are destroyed by limb amputation, thereby decreasing the amount of input into the reticular formation, the inhibitory influences are de-

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This work is from the Department of Surgery, Division of Neurosurgery, College of Medicine and Dentistry of New Jersey, New Jersey Medical School, Newark.

creased. This results in sustained activity at all levels that can be triggered repeatedly by the remaining fibers.

From the spinal cord neurone pool, fibers carrying pain impulses cross in the anterior commissure to the anterolateral part of the cord to establish the major spinothalamic tract. Some fibers pass directly from the root entry zone into the dorsal column of the same side. The fibers of the lateral spinothalamic tract then synapse in the ventral posterior lateral and posterior medial nuclei of the thalamus. There are nerve bundles in the spinal cord other than the spinothalamic tracts. These may transmit pain impulses to the brain. From the thalamus, radiate most of the pain-carrying fibers which end in the posterior central gyrus of the brain.

Practical methods are usually available for relief of some types of pain. In some, dorsal root section may be the procedure of choice. In others, spinothalamic tract section may be required. At times, both the dorsal roots and spinal cord tracts may be divided with minimal neurologic deficit. Spinal commissurotomy may be used to section four segments for pelvic pain due to cancer. Pain tract interruption may be performed by open operation or by percutaneous injection of chemicals. Under some circumstances, lumbar injection of chemicals into the subarachnoid space is effective in controlling pelvic pain associated with certain carcinomatous states. More recently, electrical stimulating devices have been used to modify appreciation of pain. Cutaneous electrical stimulation, peripheral nerve stimulation, using a bipolar stimulating electrode introduced percutaneously near the painful site, or stimulating the posterior column fibers in the spinal cord through subdurally implanted electrodes all have given varying degrees of success.

Surgical section of a dorsal column has been found beneficial in some patients with cramp-like pain in a phantom limb. Certain examples of causalgia have required stellate ganglion block or sympathetic ganglionectomy as well as, at times, peripheral neurectomy for relief of pain.

Sectioning of the spinothalamic tract in the hind and midbrain is not attempted very often because of the potential complications that may result. Evoked potential technics carried out in the operating room during the surgical procedure have been tried by some to identify the pain tracts before sectioning them.

The fibers from the spinal cord and brain stem transmitting impulses for pain end diffusely in the ventrolateral nucleus of the thalamus. As the spinothalamic system reaches the brain stem, it gives off connections to the medulla, pons, and midbrain and thereby diminishes in volume. Only a relatively few fibers enter the ventrolateral nucleus of the thalamus; therefore, lesions made surgically in this part of the thalamus give less definite relief of pain in the opposite side of the body than spinal tract section.

Because the cerebral cortex functions as a unit, lesions made in any one area (such as the postcentral sensory gyrus) fail to afford relief of pain in a specific part of the body. Sectioning of the white fiber tracts in the prefrontal region of the brain at times blunts the individual sufficiently to allow him to accept pain with only minimal emotional response. The effect on the psyche may be so profound that many neurosurgeons have become discouraged from this procedure except in very special circumstances.

It would appear, therefore, that at the present time operative procedures for relief of pain are, for the most part, limited to the skin, peripheral nerves, nerve roots, and sectioning of tracts within the spinal cord.

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65 Bergen Street

Here is an unusual paper on an often-neglected aspect of medical practice.

Some Medical Aspects of Sports

James E. D. Gardam, M.D./Millville

Increase in participation and interest in athletics in this country in recent years is such common knowledge and its impact in changing disease patterns so insidious that physicians may not be fully aware of its import. Hence, it seems appropriate to review some of the relationships which exist, or should exist, between those who participate in athletics, actively or passively, and between medicine, both organized medicine and the individual physician—in other words some of the medical aspects of sports.

We recognize that through all recorded history, man competes. He competes individually and in groups. We know, too, that children have always competed both informally and in organized fashion. As soon as a society achieves security, leisure time, and disposable income, man competes, occasionally in the informal manner of children, but more often in an organized, structured manner. Such organized competition for leisure or recreational purposes may even occur in the face of cultural deprivation—wars, depression, famine. As man develops organized competition, a structured kind of society, a subculture, the athletic society is created. Such a structure includes the competitor, the teacher or coach, who develops natural skills, the physician or trainer, who guides, protects, or aids the athlete, the spectator who encourages him, and the business structure consisting of organizers, backers, officials, and administrators.

A history of the Olympic games and the recent, popular biography of Alexander the Great, reveal the long, ancient, history of organized competitive athletics. In ancient times competition was highly organized. Training systems existed for teaching and coaching and a highly developed system of medical care for the injured, as well as special diets, exercises, and training rules for all competitors were followed. Athletics involved many levels of society.

Recent studies of Margaret Mead and Erik Erikson note that some form of competitive physical endeavor or games have existed, and continue to exist, in all societies. A great painting by Breughel illustrates games which have survived from the Middle Ages. The games with which we are familiar, today, with their rituals, rules, and technics can be traced historically through the ages. Various cultures and societies, have made startling changes yet striking similarities exist. The universality of competitive athletics is manifest ever so clearly in the fact that one single game, soccer, today is played in virtually every country in the world.

In the United States, the combination of almost unlimited space and natural resources, plus an energetic, aggressive, and innovative population has led to the great popularity of competitive athletics. In addition, the location of the United States in a temperate climate, possessing the technical and organizational expertise to provide a 35 to 40-hour work week with a high standard of living, has produced ample time and resources for the growth of athletic endeavours.

This combination of good fortunes, an ener-

getic population, and a land of ample resources, leisure time, and disposable income, is, to an extent, providing also for concurrent expansion of cultural activities: music, drama, literature, fine arts, the dance. Perhaps the advances in these areas do not exactly parallel the involvement in athletic competition. This emphasis by our nation may be faulty but athletic participation has wide popular appeal, and may involve more people for longer periods of time and with more expenditure of time, income, and national resources than do the arts.

The physician must be aware of the growth and emphasis on competitive athletics. Although as a nation we have a waiting list for hospital beds for the acutely ill, our nation can and does afford a Houston Astrodome and contemplates a sports center in the Jersey meadows. Athletic events are now held "indoors," in an air conditioned environment, on an artificial playing field, before 100,000 spectators. Over 60 per cent of all television sets in the country during the fall are turned on each Monday to watch football. One million Americans at some time on any fall weekend actively *play football.* On winter weekends uncounted millions ski.

The use of disposable time for recreation and physical exercise, and even vicarious participation, will more than likely improve the condition of life and promote health and longevity. However, physicians who regard their role as the provider of personal, life-saving medical care may not be aware of developing social phenomena that directly affect the health of their very own patients and the practice of medicine. The physicians may also fail to recognize the impact of athletics on their own medical practice.

The arbitrary selection of early September for the beginning of supervised training for high school football in New Jersey produces a variable number of days between the start of practice and the opening of school and the first game. The leading cause of death in football is believed to be heat exhaustion but there are no enforced standards for control of participation under adverse climatic conditions and little regard has been given to air pollution as a problem of affective athletics.

The medical profession should adopt a definite posture regarding ergotonic agents, anabolic hormones, and the use of oxygen and fluids in athletics. All this may be considered to pertain to football. Many other questions confront us: the use of the helmet in hockey, adequate training for scuba diving, reliable binding releases and appropriate boot height in skiing, prevention of ear injuries in wrestling, and standards for control of weight loss. One questions whether the benefits alleged to accrue from little league baseball will be obtained by development of little league football. Physicians who ordinarily devote their training and energies to the prevention and care of disease, may be totally unaware of the host of problems encountered by their patients in this special area—athletic competition or participation. This athletic environment has a morbidity and even a mortality of its own. If we acknowledge that there exist some physiologic benefits from athletic participation and competition and if, second, we acknowledge that every aspect of the life of the patients is of concern to the physician, then we must conclude that physicians should participate actively in all aspects of sports medicine to insure that their patients derive the benefits with minimal risk.

The participants in sports number among the millions on any given weekend; some sports are not contact but "collision" sports, certain individual sports have their own "peculiar" injuries, and all sports involve a patient population. It is thus necessary for the physician to involve himself in this social phenomenon not only as a physician but as a parent, and as a citizen.

Who is physically qualified to participate in athletics and for what sport? What equipment should be mandatory and who should supervise its selection? Who should be responsible for initial care of injury and transportation? Who should be responsible for playing field or court conditions and what of the safety and

care of spectators?

There are innumerable problems in athletics which have a medical aspect. One must question continuously every aspect of a sport from the health implications. Consider football. What are the appropriate dates to begin preseason training, duration of the training period, the number of games scheduled, and what should be the length of the practice session in relation to heat, humidity, air contamination, and the academic program?

When the medical aspects of a single sport are examined, then the frame of reference may become applicable to the entire athletic program. Consider the following aspects of a high school athletic program from the medical point of view. Should helmets be worn by hockey players and does a five a.m. practice session jeopardize health? Should there be medical supervision of weight reduction by wrestlers and is there a formula to define guidelines?

What is the appropriate treatment for injuries to the ear in wrestlers? Considering the 90,000 annual injuries from skiing, what safety program should be instituted for a ski team or should such a team even be sponsored by a board of education? What precautions should be instituted to prevent injuries occurring against the end walls of a basketball court? What maintenance program should be instituted for gymnastic equipment? Should little league baseball and football be under medical supervision or should such programs be discouraged or even disallowed?

A large part of our patient population is *not* exposed to diphtheria, does *not* contract smallpox, does *not* have morbidity or mortality from lung cancer or tuberculosis. This same patient population, however, is exposed to morbidity and mortality in the area of athletic activity and, moreover, only a few physicians concern themselves or are educated to understand the medical aspects of athletic competition.

If we first acknowledge that people derive physiologic benefits from athletic participation and competition and if we acknowledge that every aspect of the life of our patients should concern us as physicians, then we can conclude that physicians should participate actively in all aspects of sports medicine to insure that their patients derive all the possible benefits with maximum safety and minimal risk.

We may be confronted by inappropriate or emotional non-medical efforts to curtail or eliminate worthwhile programs. Two examples suffice: President Theodore Roosevelt was compelled by public outcry to appoint a commission to establish football rules as a result of repeated injuries and deaths in college games. Annually, several football deaths occur in the United States. Objectively, they may be related to the sport only indirectly but the amount of publicity is great and far in excess of the publicity generated by death by auto. Unless physicians are aware that a medical concern is necessary in this phase of life and unless some physicians play an active and concerned role in athletics, we may lose many of the benefits that accrue from wide participation in sports. Indeed, we may incur new problems or arbitrary, capricious, and emotional controls or deletions of entire programs.

The expanding membership and the development of research programs and analytical technics by the American College of Sports Medicine hopefully will produce a body of knowledge with a scientific basis for physician application. The development of county and state committees of practicing physicians will achieve further dissemination of knowledge and increased utilization of information applicable to health and safety in sports. Physicians with knowledge of the special medical aspects of sports should be actively affiliated with athletic staffs of institutions at all levels and boards of education—local, county, and state. Physicians should be attached to all levels of coaches, officials, and governmental and voluntary recreation boards.

Physicians, individually, must evaluate their

roles as citizens and parents. Until such time as active, continuing, and organized physician identification and participation in the medical aspects of athletics exist, individual efforts by informed physicians may have appropriate impact in improving athletic health and safety. Physicians should be concerned as parents and citizens about plant facilities, the selection and training of personnel and equipment, program development, and the safeguards applicable to participants and spectators. Physicians should be concerned that direct medical care is provided by skilled, interested, and concerned professionals with sound medical training and experience.

Physicians should be selected for athletic programs with care. They should be interested and well motivated. They should be encouraged and subsidized to continue their education in the specialized medical aspects of athletics, their exposure to liability covered by appropriate insurance, and assurance that their time and skill are adequately recompensed. The athletic physician—and he need not be a surgeon—must be concerned about and given an appropriate degree of responsibility for *every* aspect of the program. He must be concerned about the playing field, artificial or natural, the use of maintenance materials (such as lime and fertilizer, breakaway markers, the construction of fences, "insulation" of goal posts, pot holes and drainage). The physician should, at the very least, be consulted by all levels of management and his skill, knowledge, and interest be accorded recognition.

There must be concern about the sanitation of the field house, laundry, soap, clothing, and their relation to the possibility of disabling, epidemic illness, be it upper respiratory infections or furunculosis. Cooperation between, and education for, managers, players, and staff should be encouraged and continuous.

The physician must be concerned about protective equipment and know that knee injuries can be prevented by use of the rotating heel, or the soccer cleat, that kidney contusions are common and preventable, that head injuries are more frequent when the helmet fits poorly, that long hair contributes to broken noses, and that heavy sweat shirts contribute to heat exhaustion. There must be a working relationship between the coaching staff and the physician, with mutual respect for the goals to be attained.

It is the physician who must be acutely aware that environmental conditions may lead to disability, that water and salt are necessary under conditions of heat and humidity, and that practice time should vary with conditions. It was a physician who developed *Gatorade* to protect against salt and water loss.

It should be the physician, together with the coaching staff, who must endeavor to establish rapport with officials to ensure sportsmanlike conduct in competition and thereby diminish unnecessary injuries. It is the physician and coaches working together at game time, and through the year who must ensure safe conditions for all. It is recommended that the physicians be invited to participate on a continuing basis with the officers of conferences and with officials' organizations to advise on rule changes and necessity for enforcement.

The physician must work with, and advise, the administrative services on budgets to provide equipment for crowd control, resources for emergency care of spectators and insurance for players. The athletic physician is not to be considered just the kindly old man who has a good seat on the fifty yard line for varsity games; he is an integral part of the staffing for the entire program. The physician also *must* provide the best possible individual physical examination for candidates to permit participation by all who are physically qualified and to know the individual limitations of the boys who do play.

It is the physician who must advise on training and know that sixty per cent of performance is leg action—short sprints duplicate performance—long distance running is for endurance. And also it is the physician who must provide on-site diagnosis, emergency care, provision for transport off the field, and

processing to definitive care. Appropriate medical care does not end at the side line.

And further, it is the physician who must know that the most common time of injury is the second play after the opening of the second half. that contusions are the most common minor injury, that the knee injury is the most common serious injury. He must know that the highest risk on offense is to the fullback, that the highest risk on defense is to the linebackers, that the person making the tackle or block is more easily injured than the person tackled or blocked, that a moving target is not injured, that more injuries occur in preseason practice than in regular season, that more injuries occur in practice than in games, that freshman have more injuries than the varsity, that varsity substitutes suffer more injuries than regulars, and that special team players are more exposed to injury than others.

This is a brief enumeration of some of the duties and responsibilities of physicians who are concerned about the medical aspects of a single sport. The same or similar principles of medical care can be extended to *all* other athletic programs. The physician must be the source of advice on many subjects. The list is large: the use of ergotonic drugs and oxygen; the ear injury in wrestling; the tennis elbow; and the very many subjects that have been enumerated above represent a mere sampling. The conclusion is obvious. Every facet of athletics has an inherent medical aspect.

We must, therefore, conclude that competitive athletics has been a part of the life of civilized man and that it will continue to form an expanding role in his cultural life. Athletics involves a patient population which requires physician concern for the specialized morbidity and mortality and the medical problems that are inherent in competition. Many physicians are not aware of the problems and may lack the available specialized knowledge for dealing with them. However, as health professionals, physicians should be actively concerned in each one of these roles to insure the development of programs of research, prevention, treatment, and administration based on scientific principles. The athlete may participate in athletics. The physician *must* participate.

Drawer 471

Labor Preplans for NHI

Labor's leading proponent of a sweeping National Health Insurance bill, Leonard Woodcock of the United Autoworkers, engineered a tentative agreement with the Chrysler Corporation requiring the company to pay the full workers' tab for any National Health Insurance plan that comes down the pike.

It was believed to be the first such provision in a major labor settlement and made clear labor leaders' desire to have management shoulder the full cost of NHI. The agreement made dollars and sense from the standpoint of the UAW, but took some of the gloss off the repeated Woodcock assertations before Congressional committees that workers are willing to pay their fair share of any national health program.

Steven Schlossberg, UAW's general counsel, was quoted as saying that autoworkers have always supported NHI but "now they have even more incentive to press for its passage since, because of the new contract, there is no economic incentive for them to be against it."

The agreement states that in the event a National Health Insurance program is enacted Chrysler will be required to pay any direct premium levied on workers.

INFORMATION FOR READERS AND CONTRIBUTORS

The Journal, the official organ of The Medical Society of New Jersey, is published monthly under the direction of the Committee on Publication. *The Journal* is released the first week of the month, and a copy is sent to each member of the Society.

Change of Address: Notice of change of address should be sent promptly to The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey, 08605.

Communications: Members are invited to submit to *The Journal* any suggestions for the welfare of the Society, as well as comments or criticisms of material in *The Journal*. All such communications should be directed to the Editorial Office of *The Journal*. The Publication Committee reserves the right to publish, reject, edit, or abbreviate all communications submitted.

Contributions: Manuscripts submitted to *The Journal* must be typewritten, *double-spaced* on letter size (about 8½ by 11 inch) paper, and forwarded to the Editorial Office at the address below. The Publication Committee expressly reserves the right to reject any contributions, whether solicited or not, and the right to abbreviate or edit such contributions in conformity with the needs and requirements of *The Journal*. Galley-proofs of edited or abbreviated manuscripts will be submitted to authors for approval before publication. Every care will be taken with the submitted material, but *The Journal* will not hold itself responsible for loss or damage to manuscripts. Authors are required to submit an original and one copy and are urged to keep a carbon for reference. It is understood that material is submitted here for exclusive publication in this *Journal*.

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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

P. O. Box 904, Trenton, New Jersey 08605

Special Article

Community Health Education: A Challenge to Hospital and Medical Staffs

Anne R. Somers, Princeton*

Community health education is an idea whose time has come!

This is true whether one thinks in terms of the quality and effectiveness of health care, or in terms of cost and financing. It is true whether one thinks primarily in terms of the consumer/patient, the physician or other health professionals, the hospital or other institutional providers, or the third party responsible for financing.

To back up this strong statement, let me start with a couple of individual cases, based on experience at Monmouth Medical Center, and then broaden out the discussion.[1]

One Doctor, Two Patients**

Paul Brown was a 16-year old diabetic, who weighed only 104 pounds and was five feet, eleven inches tall, when he first saw Dr. Samuel Smith. He had been injecting his own insulin for over a year and doing the best he could with diet modification. He had no idea how to adjust his insulin dosage and was almost literally starving to death.

The child of a military family, with repeated household moves, Paul had been under the care of various physicians and nurses who assumed that somebody else had given him the necessary instruction. But nobody had, even though he had been hospitalized in the past. Dr. Smith referred his patient to the Monmouth Medical Center, where he attended his first diabetic education class. After discharge, Paul completed the eight-hour course, gained weight, and maintained control of his diabetes.

Mrs. Mary White, 44, a menopausal "problem diabetic" for several years, was five feet, five inches tall and weighed 235 pounds. Unable to stick to her diet, she called her physician often, always with the same problem. Dr. Smith referred Mrs. White to the hospital's diabetes class, where she gained information and seemed to benefit from the informal group "therapy" and inter-personal support which the class generated out of its own experience. After eight months, Mrs. White weighed 195 pounds; her diabetes was under better control; menopause was less of a problem; her morale was improved; and her family was deeply grateful. Said Dr. Smith, "The health education class took the albatross off my back!"

One Week in May

So pervasive has this new community health education program become that a local newspaper said recently, "For many men and women, Monmouth Medical Center is not primarily a hospital but a public school."

Between September 1, 1972, and June 1, 1973, over three thousand Monmouth and Ocean County residents, with a variety of actual or potential health problems, attended classes, conferences, or other activities sponsored by the program. Sixty-six doctors, nurses, and other health professionals were involved in the planning and teaching.

In one week in May, for example, when the program was at peak activity for the year, there were classes for patients with diabetes, expectant parents, and for parents after delivery. Colostomy care instruction, preoperative

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**Names in the vignettes are fictitious

instruction via closed-circuit television for surgical patients, and in-service training for obstetric nurses and for adolescent care nurses was also given.

At the local high school, hospital staff members taught venereal disease, drug abuse, and "family living" classes, and gave individual counseling for sickle cell disease. For those in need of immediate counseling and/or treatment, the venereal disease information hotline was open every night.

The hospital staff also held emergency childbirth and cardiopulmonary resuscitation classes for the community first aid squad and a special program for life guards.

Diabetes Education

Working with physicians, nurses, dietitians, and patients, a nurse program director designed an eight-hour evening course, which was planned to provide a core of essential information, to supplement existing patient knowledge. Individual instruction by doctors, nurses, and dietitians was also arranged for both inpatients and outpatients, who paid a five dollar registration fee, which was waived in case of financial hardship. In seven months, the program served 122 patients, with increasing referrals thereafter.

Evaluation of the program in terms of the actual health status of participants, six months after completion of the course, has started with the collection of data on weight, blood sugar, and other health indices. A similar group discharged from the hospital prior to establishment of the new program, is being studied for comparative purposes. Interhospital comparisons are being made with Morristown Memorial Hospital.

From pre- and post-course questionnaires it is already clear that patients substantially improved their understanding of diabetes and their own treatment. Prior to taking the course, 30 per cent of all patients on insulin did not understand the meaning and value of rotating the injection site; 42 per cent of those who tested their urine did not know to test the second voided specimen in the morning; 19 per cent of those who demonstrated insulin administration used improper sterile techniques. After the course, all participants understood the correct procedures, aided by charts to help them select an injection site and to record urine test results.

Diabetes teaching programs are probably the most common example of patient education in community hospitals today. However, based on pre-course questionnaires this is still an unmet need.

VD Hotline

The VD hotline operates every night from the outpatient department. It is manned by three highly motivated and specially trained college students associated with Youth Horizons, a Long Branch community group, and one adult licensed practical nurse. They have full time backup from physicians in the emergency room and/or VD clinic.

In its first five months, the hotline received over 225 calls. The frequency of calls has increased steadily as a result of favorable publicity, including radio announcements.

Precise evaluation of the program is not possible, but the number of visits to the hospital VD clinic and emergency room has increased substantially since the hotline was started. The proportion of patients going to the clinic rather than to the emergency room has increased, suggesting that more patients are seeking non-emergency treatment there, rather than in the emergency room.

Expectant Parents' Classes

Organized and taught by attending and house physicians and obstetric nurses, this popular course features the LaMaze method of psychoprophylaxis.[2] An average of 40 couples attended the course which consisted of a two and a half-hour session weekly for six weeks.

The classes were repeated six times in a year and were self-supporting by virtue of a twenty-dollar fee.

Subjective evaluation would have given this program an "Oscar," as attested to by the waiting list. The satisfaction of the increasing number of fathers attending the birth of their children may be one reason why deliveries at Monmouth Medical Center continue to rise, despite the declining local and national birth rates.

Birth data over a two-year period indicated no significant difference in methods of delivery between the "LaMaze mothers," who had taken the course, and those who had not.[3] There was no significant difference in type of anesthesia or duration of labor. Further study of the LaMaze technique[4] suggested that the Monmouth program placed inadequate emphasis on physical exercise during the latter part of pregnancy.

Other Examples

Examples[5] of community health education from other states are:

1. The Kansas City Methodist Hospital, department of pediatrics, developed a licensure program for baby-sitters. The program has been so successful that there is a waiting list of applicants for the six-week course, which is taught by physicians and nurses on the pediatric ward. The youngsters who learn skills in mothering and child psychology (that they can use the rest of their lives) receive a certificate at the end of their training and are paid 50 per cent more than untrained baby-sitters.

2. At a hospital alcoholism clinic in Lansing, Michigan, special classes are conducted three times a week for people arrested for drunken driving. Sentence is delayed pending their cooperation with this class and completion of a test at the end of the course. The judge passes sentence based on attendance at classes, attitude, and evidence of learning. In this situation, the student-offender pays the full cost and is strongly motivated to learn.

3. In Springfield, Missouri, an internist made an original attack on coronary heart disease, after he discovered that there was an average fourteen-hour delay between the first symptom of a heart attack and arrival at the hospital in his town. The physician developed an educational program on local television, teaching people how to suspect heart attack. As a result of the public information campaign, average delay was reduced to seven and a half hours.

Health education, despite the bad press and indifferent results associated with some past efforts, is still alive and well and, I am deeply convinced, in for a national renaissance during the coming decade. This is true with respect to both *patient education* and *community health education.*

Health Education and the Quality of Care

I said at the outset that health education was an idea whose time had come—both in terms of quality effectiveness and cost effectiveness. With respect to the relation of health care, as it is generally practiced in the United States today, to health status, it is a sobering fact that for all we have studied, learned, discovered, and expanded our health services during the past 50 years, we have succeeded in adding less than two years to the life expectancy of the average white man of 40.[6]

During the sixties, the over-all United States death rate ceased to improve, fluctuating between 9.4 and 9.7 per 1,000. Moreover, this over-all stability was achieved entirely by improvement in the death rates for infants (under one year) and at ages over 45. By contrast, there were substantial increases in mortality for teenagers (15-19), young adults (20-34), and the younger middle-aged (35-44). The big news, the bad news, is the rising death rate for young and younger middle-aged American men. These rising rates were particularly dramatic for blacks and were independent of military casualties.[7]

Since most of the causes of the rising death

rates among young men are related to lifestyle rather than the kind of health care they are or are not receiving, it is, of course, nonsense to blame the health care establishment for our relatively poor statistical showing in many international indices of comparative health status. On the other hand, it is increasingly clear that there is no demonstrable causal relationship between increased expenditures for health care, or even increased health care personnel, and improved health status. The missing ingredient appears to be the active understanding and cooperation of the consumer-patient. And this is where health education must be mobilized; must be made part of the average physician's armamentarium.

It has also been fashionable, for some time, to claim that the fault lies primarily with the way health care is delivered, namely, solo practice with the fee-for-service method of payment. This has been one of the chief rationalizations behind the drive for prepaid group practice or HMO's. I am personally very sympathetic both to group practice and to the HMO concept under controlled conditions. However, I do not believe there is any inherent superiority in one method of delivery as opposed to the other.

This conviction was reinforced by the findings of a recent study which involved use of particular diseases as "tracers" of the quality of care received in different medical settings in Washington, D.C.[8] The study sample consisted of 1,136 families residing in either of two communities within the city—an upper-income area and a lower-income area. The families had 2,780 children between the ages of six months and eleven years. The field test included three diseases deemed common to children in this age bracket: middle-ear infection and associated conductive hearing loss, iron-deficiency anemia, and vision disorders. The test population was using six major sources of primary health care, ranging from physicians in solo private practice to hospital outpatient departments.

"Analysis of the test data indicated that 'health status based on measures of selected tracer conditions in children of comparable demographic, social, and economic background does not differ by provider organization'—this despite the differences noted in methods used to screen, diagnose, and treat the conditions."[8]

It should be noted that this study was confined to children. Whether the same results would have obtained in the case of adults is not answered. However, I am not aware of any definitive study relating the health status of adults to the method of delivering their care. Indeed, it is difficult to see how such a study could ever be undertaken in view of the large number of variables influencing adult health.

In the effort to identify "barriers to health care," investigators at the University of Wisconsin College of Engineering canvassed a selected list of researchers, physicians, nurses, industrial engineers, planners, and administrators. On the basis of the response, 22 "barriers to quality improvement" (as opposed to "barriers to cost containment" and "barriers to accessibility") were identified. Of these, eleven (or half) involved the consumer in whole or in part. Included were statements such as the following:

"Consumers lack understanding of preventive measures."

"Consumers lack understanding of *when* services are needed."

"Communication between providers and consumers is inadequate."

"Consumers lack understanding of *how to enter* the health care system."

"Consumers and providers view service as a reactive rather than a preventive function."

"The 'medical mystique' causes consumers and trustees to hesitate to take issue with the physician."[9]

Clearly, this particular set of respondents—many of them health professionals themselves and all above average in knowledge and sophistication with respect to health care—believe that, even with respect to quality, consumers share equal responsibility with providers. My guess is that a very different picture would emerge if the survey had been applied

to the average man-in-the-street, especially to individuals with little education and little income. Within these groups one would probably still find a large proportion who believe that the doctor alone is responsible for the quality of health care and should be held almost wholly responsible for any shortcomings not only in that care but in the patients' own health status.

This, of course, is the basis for the recent deterioration in the public image of the physician. The best way to restore that image is through a determined educational effort to make the consumer realize that he himself is the principal factor in his own health. The surest way to worsen the present image is to perpetuate the myth of the physician as the authoritarian miracle worker who, alone, can bestow or withhold the gift of health from a group of passive patients.

Health Education and Costs

Finally, a word about cost effectiveness. There is no doubt that a few billion dollars, spent to teach the consumer/patient to develop a lifestyle conducive to good health and, when ill or disabled, to understand and cope more effectively with his own health problems, could turn out to be far more cost-effective than billions spent on the development of exotic new medical technology and expensive inpatient programs.

Bates[10] describes a physician in Muncie, Indiana, who "takes time to teach his patients about their own health care: how to take their temperature; what a bad throat looks like in the mirror; how to feel for lymph nodes; how to avoid diseases. He teaches mothers to find out what he'll want to know about their child's symptoms when they call him. As a result he is, single-handedly, able to take care of an astounding 4,800 people in his practice. The national average is one physicians for every 700. (Kaiser: 1/1200) And he does this by seeing only 29 patients a day. He has found that, by taking time to educate his patients to be their own paramedics, the average family only sees him for three and a half visits a year. He has taught his patients how to stay away from him and still stay healthy. The savings to them and in wear and tear on his own arteries are tremendous."

I am not suggesting that every physician should take care of 4800 patients. This would obviously be absurd in many specialties and probably undesirable in most circumstances. But if one doctor has been able to do it, without any decline in the quality of his care, then he has clearly suggested a new way of approaching the elusive problem of productivity in the health services. It opens up a new and promising approach to cost effectiveness—mobilization of the consumer/patient in his own health maintenance and health care.

Gartner and Riessman[11] suggest that this new key to productivity applies across the board in the service economy as opposed to the goods-producing sector. "Traditional notions argue that productivity in human service work cannot be increased sharply because it is not amenable to capital-intensive inputs and, as it is labor-intensive work, inputs are costly and potentially inflationary. The point, however, is that human service work is *consumer-intensive,* and that *the key to increasing productivity in this sector lies in effectively engaging and mobilizing the consumer.*" (italics supplied)

Obviously this is what the Indiana physician has done. If the reports of his success are even approximately accurate, it suggests a way to make the much-advertised "health care crisis" disappear within a few years, and to do this without having to mortgage our souls to the federal government.

The modest health education program that Morristown Memorial Hospital has undertaken, with the assistance of Rutgers Medical School, is not going to solve all your problems. But it is a beginning, an important beginning I believe. With your active cooperation—better still your leadership—it can be a significant influence on the delivery and cost of health care in this area, to the benefit of both physicians and consumers.

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New Directions in M.D. Licensure

The National Board of Medical Examiners has taken steps to implement long-range recommendations that call for new directions for evaluation, certification, and licensure of physicians. The new directions constitute an initial response to the recommendations of the Committee on Goals and Priorities whose report was recently submitted to the Board. The Committee, headed by Dr. William D. Mayer, University of Missouri-Columbia School of Medicine, spent more than two years studying what is called the "complicated, disjointed, and overlapping complex of medical examinations, certification, and licensure" in relation to the changing patterns of medical education.

The proposed new relationships between medical education and its evaluation are outlined in an article by Dr. Hubbard, President of the National Board, published July 23, 1973, in the *Journal* of the American Medical Association.

Changes envisioned by the Board include a single qualifying examination upon graduation from medical school, which, together with the medical school's evaluation, would enable state boards to grant a "permit" to practice medicine under supervision during graduate education. Then a full license for independent practice could be awarded by a state board following completion of graduate medical education and specialty board certification. For those not certified by a specialty board, alternate prerequisites for licensure would be determined by the state boards.

Beyond completion of graduate education and entry into practice, periodic evaluation of professional competence leading to recertification and perhaps re-licensure would be required throughout the professional career of the physician. Responsibility for recertification will rest, the National Board believes, with the agencies that grant specialty certification in the first instance—the specialty boards.

The National Board recognizes that the Committee's recommendations go far beyond the National Board itself and that the achievement of many of the recommendations will require coordinated and shared responsibility among the numerous agencies and organizations involved.

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

September 30, 1973

A regular meeting of the Board of Trustees was held on September 30, 1973, at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

Henry A. Davidson, M.D. . . . Observed a moment of silence in tribute to the memory of Dr. Henry A. Davidson, Editor of *The Journal* who died on August 23, 1973.

. . . Adopted the following memorial resolution and approved a contribution to the Student Loan Fund in Dr. Davidson's memory.

Whereas, Almighty God, the supreme author of life and action, in his unchallengeable wisdom, has written "finis" to the vigorous life history of Henry A. Davidson, M.D.; and

Whereas, through a generation of service, Doctor Davidson has won national renown as the illustrious Editor of *The Journal* of The Medical Society of New Jersey; and

Whereas, by his literary genius, his kindly wit, and his profound expansive professional knowledge, he has consistently reflected credit upon The Medical Society of New Jersey; now therefore be it

RESOLVED, that The Medical Society of New Jersey records its lasting indebtedness to Henry A. Davidson, M.D., Editor-extraordinaire, literary and scientific authority par excellence, distinguished physician, and delightful and amiable associate, whom others may succeed but no one can replace; and be it further

RESOLVED, that it records its heartfelt grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of this meeting and that another copy, suitably prepared, be presented to his bereaved widow and family in token of heartfelt sympathy.

Annual Meeting (1973) . . . Noted that films taken at the 1973 House of Delegates meetings will be shown on Sunday, December 9, 1973, 10 p.m., channel 4.

Committee on Long Range Planning and Development . . . Directed that a follow-up to the letter of July 30 from President Boylan to each county medical society requesting nominees for appointment to the Committee on Long Range Planning and Development be sent to those component societies that did not reply.

Public Relations . . . Approved the following recommendation, concerning implementation of the House of Delegates directive to the Council on Public Relations to acquire television exposure, relating to participation in a program titled "The Killers," to be aired in five one-hour segments (November through March) :

That the Board approve the commitment of $15,000 to this project, conditioned upon the concurrence of the Chairman of the Council on Public Relations, and that the staff be authorized to explore funding possibilities from the New Jersey Regional Medical Program, the Cancer Society, the Heart Association, and the Lung Association.

Legislation . . . Approved the following recommendations from the Council on Legislation:

1. That the Board of Trustees authorize the registration of Martin E. Johnson, Executive Assistant, MSNJ, as a lobbyist, as required under New Jersey Law.

2. That the Board of Trustees approve the positions indicated on the following bills.

S-852 —To require every school bus transporting children to and from school shall be staffed with a monitor at least 16 years of age. *DISAPPROVED,* because the effect of the bill is already covered in the voluntary administration of school policies.

S-1041 —To regulate the practice of ophthalmic dispensing. *DISAPPROVED,* because this bill places unwarranted restrictions upon the practice of Ophthalmology and Medicine and would expand the practice of ophthalmic dispensers and ophthalmic technicians without providing circumstantial safeguards for the public good.

S-1054 —To provide for testing of motor vehicle fuels to determine the presence of factors which may contribute to air pollution. *NO ACTION.*

S-2238 —To prohibit profit-making medical referral services. *APPROVED.*

S-2239 —To limit circumstances under which a report of a referral for abortion services or an inquiry or request therefor may be furnished to provide for actual and exemplary damages for wilful violation. *APPROVED.*

S-2256 —To provide that a notice of food establishment health deficiency shall not be posted on the premises for 10 days where the deficiency does not create an immediate health hazard. *DISAPPROVED,* because, this bill does not consider the ten day interval in which the general public would be exposed to unsanitary conditions between detection and initiation of suspension.

S-2281 —To regulate the practice of dentistry and dental hygiene and to repeal Chapter 6 of Title 45 of the Revised Statutes. *ACTION DEFERRED,* pending further information from the New Jersey Dental Association.

S-2286 —To provide that any person, other than a person licensed to practice medicine and surgery, who performs an abortional act shall be guilty of a high misdemeanor. *APPROVED*

S-2298 —To increase license and registration fees, to increase the members of the Board of Optometrists from 5 to 7 members, to provide for branch office transfer licenses, to increase penaltics for violations and other amendments to the act concerning the practice of optometry. *ACTION DEFERRED,* pending further information from the New Jersey Academy of Ophthalmology and Otolaryngology.

S-2315 —Designated "The Catastrophic Illness Assistance Act of 1973"; to authorize program for State assistance; appropriates $200,000. *APPROVED*

S-2317 —To provide for direct billing in certain instances for clinical laboratory services. *APPROVED*

S-2323 —To create a commission to develop a State plan for the delivery of mental health services; appropriates $25,000 therefor. *APPROVED*

S-2324 —To establish a Division of Chronic Illness Control and an Advisory Council on the Chronic Sick within the State Department of Health; to provide for state assistance to persons suffering from chronic illnesses. *APPROVED*

A-836 —Requires every school bus to be staffed with a monitor at least 16 years of age in addition to the driver; effective at the commencement of the school year next succeeding enactment. *DISAPPROVED,* because the effect of the bill is already covered in the voluntary administration of school policies.

A-2420 —To create a Mental Treatment Standards Committee to establish minimum standards of treatment for the mentally ill in State mental institutions. *ACTION DEFERRED,* pending further information from the Council on Mental Health.

A-2138 —To permit equipping of school buses with seat safety belts, anchorage units, padding and other safety restraints determined necessary by local school boards. *APPROVED*

A-2440 —To permit use of suitable restraining devices other than auto seat safety belts which meet standards of the Federal Department of Transportation. *APPROVED*

A-2471 —To provide that no authorization for construction or operation of any solid waste disposal facility shall be given for one within a radius of 2 miles of any public or private school, hospital, nursing home or similar institution without consent of the institution. *DISAPPROVED,* because this bill is in conflict with the expertise available in the Department of Environmental Protection and unwarrantly grants an absolute veto to certain organizations in disregard of public health.

A-2485 —To prohibit employers from preventing employees who are volunteer firemen, volunteers in first aid, rescue squads or ambulance drivers from responding to alarms during hours of employment. *NO ACTION*

A-2490 —To permit freeholders of a county with no hospital for care of cerebral palsy children to appropriate $100,000 for such care and in first class counties to permit appropriation of $150,000. *APPROVED*

A-2502 —To require every school bus, public or private, transporting children to and from school to be equipped with electric identification and warning lamps and appropriate signs or legends. *APPROVED*

A-2503—To require all school bus drivers, public or private, to submit to a medical examination for the presence of alcohol, narcotics or habit-producing drugs. *APPROVED*

A-2509 —To provide that a drug shall be deemed mislabeled if it does not contain a label with a date after which the quality or potency of the drug is not substantially equivalent to that on the date it was manufactured or produced and to permit the Department of Health to establish a list of expiration dates. *APPROVED*

A-2511 —To establish a "Burn Treatment Center" in the College of Medicine and Dentistry. *APPROVED*

A-2519 —To require the Department of Environmental Protection to adopt standards for the control of human excrement and all other hazardous and waste liquids to be enforced by local boards of health. *APPROVED*

A-2532 —To require physical and mental examinations for all school crossing guards. *APPROVED*

TO BE NOTED AND FILED

S-2316 —To proscribe manufacture, preparation and sale of unwholesome meats and meat-food by-products as defined.

SR-2012—To request the Department of Health and Education to cooperate with hearings to be held by the Sickle Cell Disease Commission on May 19, and to suspend all school testing and screening for sickle cell disease pending the report of the Commission.

A-2521 —To appropriate $3,593,726 to the Greystone Park Psychiatric Hospital.

ACR-2051—To create a Commission on Mental Health Services to study and evaluate the State's institutions and service for the mentally ill.

ACR-2055—To make application to Congress to call a convention for the purpose of proposing an

amendment to the United States Constitution reaffirming the "right of life" as a fundamental right which shall apply to all human beings.

AJR-2012—To congratulate and commend the Newark Beth Israel Medical Center, staff and all participants in the successful development of the nuclear powered heart pacemaker.

AR-2025—To direct the Air, Water Pollution and Public Health Committee of the Assembly to study the uses and effectiveness of amphetamines and means of regulating the use of this drug.

AR-2033—To memorialize the President of the United States and the Secretary of Health Education and Welfare to restore suspended funding for the Community Mental Health Center Act.

Coordination of Educational Activities . . . Approved the following recommendation, as amended by the Board (italics indicate amendment), from the Committee on Medical Education:

That certain continuing medical education programs be listed as sponsored by MSNJ's Committee on Medical Education, the Academy of Medicine of New Jersey, *the New Jersey Academy of Family Physicians,* and the Office of Continuing Medical Education, College of Medicine and Dentistry of New Jersey.

Health Care Administration Board . . . Directed that Legal Counsel draft a letter to the Department of Health asking for an explanation of the difference between a health care facility and the private practice of medicine as it relates to a directive from the Commissioner of Health to the Summit Radiological Associates to cease radiologic consultation and service at a new office until a certificate of need has been acquired. It was Legal Counsel's opinion that private practitioners of medicine are excepted from the definition of institutional facilities under Chapter 136, PL 1971, Section 2 (B).

Health Professions Education Master Plan Advisory Committee . . . Authorized President Boylan to make appointments to the Health Professions Education Master Plan Advisory Committee. (Dr. James A. Rogers and Dr. John J. McGuire were selected.)

Editor of The Journal . . . Approved the report of the Committee on House Maintenance, Staff Policies, and Personnel Relations, including the appointment of Arthur Krosnick, M.D. of Trenton, as Editor of *The Journal,* effective October 1, 1973.

Trustees' Minutes

October 21, 1973

A regular meeting of the Board of Trustees was held on October 21, 1973, at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Group Practice of Radiology . . . Concurred in the following action taken by the Executive Committee and directed that a copy of the President's letter to the Department of Health, and any information that may evolve in the future, be disseminated to the component medical societies and to the staff presidents of New Jersey hospitals.

In response to a report, that was to be presented to the Health Care Administration Board on October 23, that would adopt as State policy the position that therapeutic radiology, diagnostic radiology, laboratory services, and physical medicine, when practiced by a group of physicians, or even a single physician, would require a certificate of need, President Boylan, in a communication dated October 19th, indicated that the Society is opposed to such action and supports the minority opposition because:

1. The legislation requiring the certificate of need clearly excepts the "physician in his private practice;"

2. It is in the best interest of the patient and the taxpaying public to give licensed physicians the opportunity to provide their services in a less costly delivery system;

3. When the legislation was originally proposed by Senator Dumont, representatives of this Society on several occasions met with him and laboriously studied and redrafted the language to its present statutory form with the clear understanding that the physician in his private practice was "excepted."

Public Knowledge—Resolution #14, 1973 House of Delegates . . . Approved the following recommendation from the Council on Medical Services concerning Resolution #14 (1973) which called for fee schedules to become public knowledge and that finances of health insurance carriers be open to public scrutiny:

That the Bergen County Medical Society be informed that the Council on Medical Services reached the decision that Resolution #14, "Public Knowledge," is impracticable for implementation.

Health Insurance Carriers—Resolution #15, 1973 House of Delegates . . . Approved the following recommendation from the Council on Medical Services concerning Resolution #15 (1973) which called for a limitation on the relationship of health insurance carriers with patients, to payment for covered services rather than judgments on quality or need of medical care:

That, since the intent of Resolution #15, "Health Insurance Carriers," has been resolved through the Medicare Administration and future matters may be within the scope of the New Jersey Foundation for Health Care Evaluation, no further action is necessary.

Acupuncture . . . Voted to defer action on the following recommendations from the Council on Medical Services until the November meeting so as to have the results of a Board of Medical Examiners meeting which representatives from MSNJ will attend whose purpose is the formulation of a statement on acupuncture:

1. That determination of a position on acupuncture by The Medical Society of New Jersey await documentation and evaluation; and

2. That members of The Medical Society of New Jersey be covered in Class 5 (not specifically anesthesiology).

Apportionment of Delegates . . . Approved the following recommendations from the Ad Hoc Committee to Study Apportionment of Delegates:

1. That the elected delegation to The Medical Society of New Jersey House not exceed 400 members;

2. That, as soon as possible after the close of the individual calendar years, the Secretary be authorized to establish the apportionment ratio for elected delegates, bearing in mind that the total number of elected delegates should be as close to, but not in excess of, 400 as is possible to maintain; and

3. That, in accordance with established custom, the Secretary, in early January of each calendar year, notify the component societies as to the number of elected delegates to which they are to be entitled for the pending annual meeting.

Comprehensive Health Plan for New Jersey . . . Authorized the Executive Committee to designate MSNJ's representatives to meet with the Director of the Comprehensive Health Planning Agency to assist in revising the Comprehensive Health Plan for New Jersey for the coming year.

School of Professional Psychology . . . Authorized the issuance of a communication to the President of CMDNJ, indicating the Society's support of the concept that administrative responsibility for the development of a School of Professional Psychology be lodged within the College of Medicine and Dentistry of New Jersey.

Search Committee for Dean of School of Allied Health Professions . . . Authorized the Executive Committee to submit nominations to the President of CMDNJ for membership on the Search Committee to Identify Candidates for the Position of Dean of the School of Allied Health Professions.

Medical Education Program for South Jersey . . . Authorized the Executive Committee to submit nominations to the President of CMDNJ for membership on an advisory committee that would work with the Board of Trustees and the administration of CMDNJ in identifying candidates for dean and in assisting the College in its planning in South Jersey.

CLINICAL NOTES

Readers of THE JOURNAL are invited to submit personal contributions for this new page. Material of general interest, which can be concisely summarized (one or two paragraphs—up to 150 words), and does not require a thorough report, is preferred. If you have a successful new procedure, a brief practical suggestion, or a bizarre or unusual clinical experience you would like to share with your colleagues, please send it to us (PO Box 904, Trenton 08605) for "Clinical Notes."

Diagnostic Patterns in Disability: New Jersey and the Nation

This short statistical analysis of data compiled by the Social Security Administration shows the extent and nature of New Jersey's participation in the social security disability program. It compares some of the State's data with national averages, and includes a comparison of worker disability allowances by diagnostic groups for New Jersey and for the United States. This item was prepared by the Division of Disability Determinations, New Jersey State Department of Labor, Eric H. Wolf, M.D., Medical Director.

Under the provisions of the social security disability program, the nation's largest disability plan, a worker under 65 can receive monthly benefits if he or she becomes unable to work due to a mental or physical impairment that has lasted—or is expected to last—at least 12 months or is expected to result in death.

More than 96 million workers can count on monthly cash benefits in the event of such severe and extended disability. In addition, the dependents of these workers are eligible for monthly benefits. Over 1.8 million workers and 1.4 million dependents are now receiving disability benefits at the rate of $5 billion a year.

Currently 54,061 disabled workers in New Jersey are collecting $10,230,776 a month in benefits. In addition, 7,888 wives or husbands of disabled workers and 24,282 children of disabled workers in New Jersey are receiving $492,190 and $1,428,523 respectively.

Diagnostic pattern studies for disabled workers in New Jersey were last tabulated in 1970. In that year, 11,415 newly disabled workers were added in New Jersey. Nationally the list of disabled increased by 350,384.

Table 1 compares the frequency of diagnostic groups in New Jersey with the United States over-all. It shows that diseases of the circulatory system comprised the largest diagnostic group in the country in 1970. Diseases of the musculoskeletal system and mental disorders, including psychoneurotic and personality disorders, were the second and third largest diagnostic groups, respectively. All states do not, however, follow this pattern.

Within these over-all diagnostic groups, the most prevalent *primary diagnosis* in both New Jersey and the nation in 1970 was chronic ischemic heart disease. New Jersey recorded 2,698 cases that year. The nation's second most common primary diagnosis, schizophrenic disorders, accounted for 547 cases in New Jersey. Following these, in order of decreasing national prevalence, was osteoarthritis and allied conditions, with New Jersey reporting 326 cases, followed by emphysema with 430 cases. There were 299 cases of displacement of intervertebral disc in New Jersey; 378 cases of diabetes mellitus; and rheumatoid arthritis and allied conditions accounted for 234 cases in New Jersey that year. Cerebrovascular disease, listed eighth among the most prevalent primary diagnoses in 1970, recorded 363 cases in New Jersey; malignant neoplasm of trachea and lung 183 cases; and neuroses ranked tenth with 123 cases.

Table 1.—Social Security Worker Disability Allowances 1970—Diagnostic Groups

Diagnostic Group	United States		New Jersey	
	Cases	Percent	Cases	Percent
Diseases of the circulatory system	108,906	31.1	4,103	35.9
Diseases of the musculo-skeletal system	52,086	14.9	1,293	11.3
Mental, psychoneurotic, and personality disorders	38,406	11.0	1,239	10.9
Neoplasms	36,095	10.3	1,220	10.7
Accidents, poisonings, and violence	28,231	8.1	710	6.2
Diseases of the respiratory system	24,254	6.9	603	5.3
Diseases of the nervous system and sense organs	22,575	6.4	685	6.0
Allergic, endocrine system, metabolic, and nutritional diseases	13,141	3.8	541	4.7
Diseases of the digestive system	9,051	2.6	410	3.6
Infective and parasitic diseases	8,760	2.5	353	3.1
Other	8,875	2.5	258	2.3
Total	350,384	100.0	11,415	100.0

CMDNJ Notes

The College of Medicine and Dentistry of New Jersey has continued to make progress during the present academic year in a number of areas:

1. *New Appointments*—Dr. Harold Kaminetzky has been installed as Dean of CMDNJ—New Jersey Medical School. Dr. Morris Shaffer, formerly of Tulane University School of Medicine, will shortly become the first permanent Dean of CMDNJ—Graduate School of Biomedical Sciences. At Martland Hospital, Florence Gaynor, formerly of Sydenham Hospital, New York, was appointed Executive Director, New Jersey Medical School Teaching Hospitals.

2. *Accreditation*—The two medical schools and their respective hospitals, and the dental school have all been fully and unconditionally accredited for the first time.

3. *Conversion to a Four-Year Program at CMDNJ—Rutgers Medical School*—With the recruitment of a clinical faculty, including 64 clinicians and department chairmen in pediatrics and family practice, final steps have been taken for conversion to a four-year program at Rutgers Medical School. M.D. degrees will be granted for the first time in June 1974. In addition to Raritan Valley Hospital, Muhlenberg Hospital, and Hunterdon Medical Center, affiliation contracts have been arranged wtih Middlesex General, Morristown Memorial, and St. Peter's Hospitals, and the Medical Center at Princeton.

4. *Education of Students from Minority and Disadvantaged Groups*—New Jersey Medical School increased the enrollment to 96 students for the Students for Medicine Program in the summer of 1973. A tutorial program, aimed at assisting entering medical students with specific deficiencies, provided 1,000 hours of tutorial contact during the 1972-1973 school year. The New Jersey Medical School admitted 28 minority students and 6 women, and Rutgers Medical School enrolled 16 minority students and 36 women in 1973. There were 3 minority students and 19 women who entered the Graduate School of Biomedical Sciences.

5. *Special Programs*—A *breast cancer* screening program has been established in Newark. New techniques for early detection will be applied to 5,000 or more asymptomatic women. A multiple-risk *heart disease* research program, based on hypertension, lipid disturbances, and smoking, has begun. An attempt will be made to modify risk factors and evaluate change in relation to incidence of heart disease. *Proline,* a substance related to collagen production, is being studied from the viewpoint of healing and scar tissue formation. The RMS—*Institute of Mental Health Sciences* has developed an innovative approach to treatment, utilizing intensive ambulatory care and brief hospitalization. The staff of the Institute also deals with unusual situations, such as observation, evaluation, and intervention (where needed) for teachers and programs of special education for disturbed children. Such observations have been made on location in the Institute for extended periods.

6. *Internship and Residency Programs*—Internships and residency training in medicine and pathology have been approved at Raritan Valley Hospital (Green Brook).

7. *Medical Waiver Program*—Mr. Richard Durbin, Vice President for Planning and Development, has been appointed acting director of the Medicaid Waiver Program for 90 days. This action, plus the potential role of Martland Hospital, as a component institution, adds to the CMDNJ's mission in the development and monitoring of the program.

SUPPORT THE WIDOWS AND ORPHANS SOCIETY

Communicable Diseases in New Jersey

The following communicable diseases were reported to the Communicable Disease Control Program of the New Jersey State Health Department during October 1973:

	1972 October	1973 October
Aseptic meningitis	47	32
Primary encephalitis	0	3
Hepatitis: Total	236	146
Infectious A	187	69
Serum B	49	28
Unspecified	0	49
Malaria: Total	1	0
Civilian	1	0
Meningococcal meningitis: Total	2	2
Military	1	0
Civilian	1	2
Mumps	28	23
German measles	3	5
Measles	10	21
Salmonella	112	120
Shigella	27	34

Salmonella

This fall has been marked by two major foodborne epidemics in New Jersey, one due to staphylococcal contamination and the other related to food contamination by *Salmonella typhimurium*. The similarity and differences are illustrative of the spectrum of disease encountered in foodborne epidemics.

On September 26, 1973, there was an outbreak of gastrointestinal illness among school children of the Phillipsburg school system. The problem was extensive within the elementary schools and the middle school, without involvement of the high school or other sectors of the community. There were 418 cases (defined as having nausea, vomiting, cramps and/or diarrhea). The noon meal served to the students was epidemiologically implicated with a mean incubation period of 4.6 hours. The cases were characterized by abrupt onset, often with nausea or cramps, followed shortly by vomiting and/or diarrhea. The symptoms were generally self-limited (average duration 7.8 hours). Most of the patients required only symptomatic treatment at the local emergency rooms. Five hospitalizations for more severe symptoms were required. The egg salad served in the schools was implicated by food-specific attack rates, and culture revealed significant contamination with coagulase positive staphylococci as well as coliforms and fecal streptococci. No source for the staphylococci was found, but a break in technique with lack of refrigeration was documented.

Over a three-week period an unusually high number of patients admitted with diarrheal illness due to *Salmonella typhimurium* was noticed in a northern New Jersey hospital. A nearby hospital noted a similar incidence. The patients resided in several communities in the vicinity of the hospitals.

A local delicatessen was used by nearly all patients questioned. Hoagies containing at least sliced meat, lettuce, and tomatoes were implicated. An inspection of the store revealed numerous deviations from sanitation standards, including lack of hot water and the absence of a sanitizing agent. Utensils and equipment were not being properly cleaned; meats were not properly refrigerated. There was a history of diarrheal illness among several employees, four being positive for *S. typhimurium* as well as the owner-manager. Environmental swabs taken from a tomato slicing machine were also positive for *S. typhimurium*.

There were 50 documented cases in the outbreak, including three food handlers. Ten cases were probably related to secondary spread. The clinical syndrome was quite severe with hospitalization of 60 per cent of the cases.

The epidemic was controlled by clean-up of the delicatessen and removal of the culture positive food handlers until they had been successfully treated. Since control measures have been instituted there have been no new cases reported.

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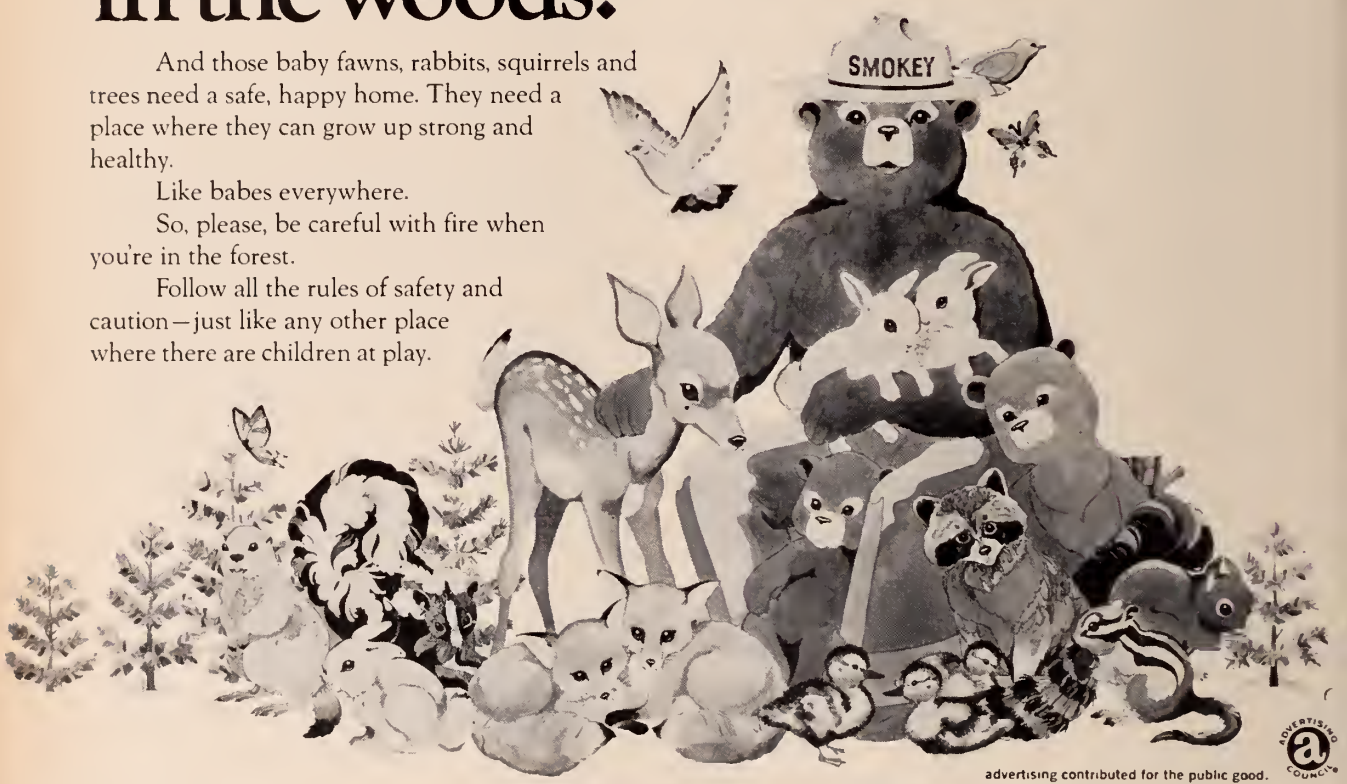
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ADVERTISING COUNCIL

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

ANESTHESIOLOGY— George D. Tedesco, M.D., 801 Inverness Avenue, Apt. B-13, Nashville, Tennessee 37204. Buenos Aires 1970. Group. Available July 1974.

GASTROENTEROLOGY— Robert A. Pastore, M.D., 12262 East Arizona Drive, Aurora, Colorado 80012. Georgetown 1964. Board certified. Group or hospital. Available July 1974.

GENERAL PRACTICE— Suresh C. Doshi, M.D., 104-2A Oakville Drive, Pittsburgh, Pennsylvania 15220. University of Bombay 1961. Group, partnership, or house physician. Available.

Joseph Weiss, M.D., 42-B Appletree Lane, Old Bridge 08857. St. Louis 1973. Group, partnership or emergency room (no OB). Available July 1974.

INTERNAL MEDICINE— Ernest T. Bajpai, M.D., 111 East Mont Lane, Sicklerville 08081. Prince of Wales (India) 1955. Board eligible. Corporation, group, or partnership. Available July 1974.

Robert I. Birns, M.D., 2185 Lemoine Avenue, Fort Lee 07024. Washington University (St. Louis) 1970. Board eligible. Subspecialty, pulmonary medicine. Hospital, group, partnership, or solo. Available July 1974.

Kumar Ram Mohan, M.D., 264-08 Langston Avenue, Glen Oaks, New York 11004. Medical College, University of Madras (India) 1968. Board certified. Subspecialty, gastroenterology. Group, associate, or partnership. Available July 1974.

Austin M. Pattner, M.D., 5960 Culzean Drive, Dayton, Ohio 45426. SUNY (Syracuse) 1966. Board eligible. Subspecialty, nephrology. Group or partnership. Available September 1974.

David A. Ingis, M.D., 2411 Woodmere Drive, Cleveland, Ohio 44118. NYU 1968. Board certified (IM), Board eligible (GE). Group or partnership. Available.

Alfred Munzer, M.D., 2120 Brooks Drive, Suitland, Maryland 20028. SUNY, Downstate, 1968. Subspecialty, pulmonary diseases. Board certified. Group, partnership, or hospital. Available July 1974.

OBSTETRICS-GYNECOLOGY— Vasant V. Dalal, M.D., 10 Lamont Avenue, Apt. 11, Trenton 08619. King Edward Memorial Hospital (Bombay) 1962. Group, associate, or house physician. Available January 1974 —as house or institutional physician available now.

Bohdan Malyk, M.D., 1106 Winding Road, Dover, Delaware 19901. Jefferson 1968. Board eligible. Group or partnership. Available September 1974.

Dhan K. Chettri, M.D., 39 Wendover Road, Rochester, New York 14610. Calcutta Medical 1958. Board eligible. Group, partnership, or solo. Available.

Anant Ram Bhati, M.D., 506 Dixmyth Avenue, Cincinnati, Ohio 45220. Jaipur (India) 1964. Board eligible. Available 1974.

Richard J. Malafy, M.D., New Britain General Hospital, New Britain, Conn. 06050. New Jersey Medical School 1971. Group, partnership, or solo. Available July 1974.

ORTHOPEDICS— Edmund R. Kappy, M.D., 231 Palisade Road, Elizabeth 07208. New York Medical 1967. Board eligible. Group, associate, or partnership. Available.

PATHOLOGY— Khwaja A. Siddiqui, M.D., 454 Garden Boulevard, Garden City, New York 11530. Kabul University (Afghanistan) 1962. Board eligible. Group, partnership, solo. Available.

Yadoolah Gorji, M.D., 3455 Street Road, Witherspoon #8, Cornwells Heights, Pennsylvania 19020. Tehran 1964. Board eligible. Hospital practice. Available August 1974.

PEDIATRICS—Stephen King, M.D., 3417 High Street, Dover, Delaware 19901. SUNY (Downstate) 1969. Group or partnership. Available September 1974.

Wen-Hsiung Lu, M.D., 3015 Tall Pine Lane #6, Jacksonville, Florida 32211. National Taiwan University 1963. Board eligible. Subspecialty, pediatric nephrology. Group or partnership. Available January 1974.

B. S. Paraswanath, M.D., 1005—18th Avenue, North, Nashville, Tennessee 37208. Mysore Medical College 1965 (India) Board certified. Subspecialty, neo-natology. Group or partnership, institutional or clinic. Available January 1974.

Hing-Ling Taang, M.D., One Bogardus Place, Apt. 2-N, New York 10040. Wuhan Medical College (China) 1960. Board eligible. Group, partnership, or pharmaceutical company. Available July 1974.

PSYCHIATRY—Charles D. Semel, M.D., 6303 Willowood Lane, Alexandria, Virginia 22310. Cornell 1968. Partnership, group, or solo. Available July 1974.

Gary L. Portadin, M.D., 1059 Lexington Avenue, New York 10021. NYU 1970. Board eligible. Group, partnership, solo, hospital. Available July 1974.

RADIOLOGY— Richard J. Rizzuti, M.D., 4774 West Braddock Road, Alexandria, Virginia 22311, SUNY (Downstate) 1968. Board certified. Group or partnership. Available July 1974.

William J. Cosgrove, M.D., 463 Harris Drive, Watertown, New York 13601. Georgetown 1933. Board certified. Full-time or part-time with individual, group, or hospital. Available.

SURGERY—Chong Wook Lee, M.D., 1945-20A Eastchester Road, Bronx, New York 10461. Yonsei Medical College, Seoul (Korea) 1963. Board eligible. Subspecialty, cardiothoracic surgery. Group, partnership, or solo. Available July 1974.

Arindam Purkayastha, M.D., Box 554, Johnson City, New York 13790. University of Calcutta (India) 1963. Board eligible. Group, partnership, or solo. Available.

Peter A. Haas, M.D., 2098 Butler Pike, Plymouth Meeting, Pennsylvania 19462. Budapest 1950. Board eligible. Group, partnership, solo. Available.

Ratnakar R. Andalkar, M.D., 11 Amherst Street, Biddeford, Maine 07005. Manglore (India) 1968. Solo, partnership, or group. Available July 1974.

THORACIC SURGERY—Jack Lee, M.D., 860 Harrison Avenue, Apt. 805. Boston, Massachusetts 02118. New York Medical 1965. Board eligible. Group or partnership. Available January 1975.

UROLOGY—David J. Samara, M.D., 851 East Homestead Village, Rochester, Minnesota 55901. American University of Beirut 1969. Board Eligible. Group or partnership. Available July 1974.

Mohammad N. Jam, M.D., 2905 North Charles Street, Apt. 105. Baltimore, Maryland 21218. Tehran 1964. Board eligible. Group or partnership. Available.

Mohamed F. Abidin, M.D., 245 Ogden Avenue, Jersey City 07307. Damascus (Syria) 1964. Board eligible. Group, partnership, solo. Available.

Harris D. Slavock, M.D., 15 Merion Lane, Willingboro 08046. Northwestern 1969. Board eligible. Group, partnership, or association. Available June 1974.

Therapeutic Drug Information Center

The New Jersey Regional Pharmaceutic and Therapeutic Drug Information Center, located at the Valley Hospital, Ridgewood, New Jersey, serves as a source of information on specific problems, articles, and reports concerning pharmaceutic and therapeutic information. A specialized library maintained by the Center contains complete information about U.S., foreign, investigational, and proprietary drugs, including their identification, availability, interactions, compatibility, side effects, dosage, adverse reactions, and so on.

The Center is staffed by trained pharmacists. Jack M. Rosenberg, Pharm. D., Associate Professor of Pharmacy and Director of Drug Information, Brooklyn College of Pharmacy, LIU, serves as Consultant Director. Salvatore Peritore, M.S., serves as Project Director, and Kenneth Anderson, Assistant Project Director.

The service is provided free, open seven days a week, and is available by telephone—(201) 445-4900, extension 304. To date, over 2,000 questions have been received by the Center, the majority from physicians. Below are three questions and answers handled by the Center recently.

1. Do you have any information concerning teratogenic effects associated with salicylates?

Side Effects of Drugs[1] states "the teratogenicity of salicylates in laboratory animals is beyond doubt, but the significance of these findings in relation to the consumption of salicylates in humans is difficult to assess."

Nora, *et al.*[2], in a study of 240 pregnant women determined their exposure to potentially teratogenic agents and the incidence of major anomalies that occurred in their offspring. Two out of twelve women who ingested salicylates alone or in combination with other drugs during the first trimester, and three out of 155 women taking salicylates later in pregnancy had infants with major anomalies.

In a retrospective controlled study of 383 birth defects, Richards[3] demonstrated an association between congenital malformations and the consumption of salicylates during the first trimester of pregnancy.

Published studies do not permit definite conclusions to be drawn concerning the effects of salicylate consumption by humans on the incidence of teratogenicity, but certainly indicate that great caution must be exercised in using such drugs during pregnancy.

References:

[1] Meyler, L., and Herxheimer, A.: *Side Effects of Drugs*. Vol. 7. Excerpta Medica, Amsterdam, 1972, p. 151

[2] Nora J. J., *et al.*: Maternal Exposure to Potential Teratogens, *JAMA*, 202:1605 (1967)

[3] Richards, I.D.G.: Congenial Malformations and Environmental Influences in Pregnancy, *Br J Prev Soc Med*, 23:218 (1969)

2. Do you have any information regarding the use of pyridoxine (vitamin B-6) to suppress lactation?

Foukas[1] recently reported the results of a 254-patient double-blind study that compared the efficacy of diethylstilbestrol, pyridoxine, and placebo to suppress lactation in post partum patients.

A course of treatment consisted of one tablet three times a day for six days beginning on the second or third day after delivery to rule out women with deficiency or failure of lactation. Identically appearing tablets were used, each containing either 5 mg diethylstilbestrol, 200 mg pyridoxine, or placebo.

Ninety-five per cent of the women treated with pyridoxine had their lactation successfully suppressed

within one week, compared to eighty-three per cent for diethylstilbestrol and seventeen per cent for the placebo. The speed with which symptoms were relieved also differed conspicuously: ten hours for pyridoxine, over 24 hours for patients on diethylstilbestrol, and several days for those given placebo.

The exact mechanism of how pyridoxine suppresses lactation is not known. It is postulated, however, that pyridoxine promotes the natural conversion of DOPA to dopamine in the hypothalamus.

It has been previously observed that increased hypothalamic concentrations of dopamine markedly inhibited the secretion of the hormone prolactin which is responsible for milk secretion.[2]

References:

[1] Foukas, M.D.: An Antilactogenic Effect of Pyridoxine, *J Obstet Gynaecol Br Commonw* 80:718-720 (August 1973)

[2] Kamberi, I. A., *et al.: Endocrinology* 88:1012 (1970)

3. Do you have information concerning the dependence-producing potential of pentazocine (Talwan®)?

A recent review published by the Council on Drugs of the American Medical Association indicates 263 published and unpublished cases of alleged dependence to pentazocine have been reported.[1] The information on 72 of these cases lacked sufficient evidence or indicated lack of dependence. Of the other 191 cases, 116 could be classified as instances of definite dependence. The report indicates that the information obtained from these cases is similar to that found earlier, in that 75 per cent of the patients who had become dependent on pentazocine could be classified as "dependence-prone."

In direct addiction studies, physical dependence did develop with prolonged administration of pentazocine. When it was discontinued abruptly, definite abstinence signs appeared which were much milder and differing somewhat in type from morphine abstinence signs.[2]

Swanson, *et al*[3]., have analyzed the chief features of pentazocine abuse in a review of 30 patients referred to a psychiatric service for management of drug abuse. In this specific population, pentazocine dependency was manifested by psychologic dependence, tolerance, physical dependence with mild abstinence symptoms and drug-seeking behavior.

Although the abuse liability is low, continued control of pentazocine by physicians and pharmacists through conscientious prescribing and monitoring is necessary to prevent misuse.

References:

[1] Department of Drugs: Use and Misuse of Pentazocine, Drug Commentary, *JAMA*, 225:1530-1531 (Sept. 17, 1973)

[2] Council on Drugs: The Misuse of Pentazocine, *JAMA*, 209:1518-1519 (Sept. 8, 1969)

[3] Swanson, D. W., *et al: Hospitalized* Pentazocine Abusers, *Mayo Clin Proc*, 48:85-93 (Feb. 1973)

The Scientific Exhibits — 208th Annual Meeting

The following information is pertinent to the scientific exhibit display at the 208th Annual Meeting of this Society, May 11 to 14, 1974. Those interested in participating may use the application form on page 961. (Please complete both sides.) Remove the page from *The Journal* and mail directly to John J. Thompson, M.D., Chairman, Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605.

Policy—It is the policy of the Committee on Scientific Exhibits of The Medical Society of New Jersey, in instances where a pharmaceutical company has aided in the production of an exhibit—either through financing or supplying products—that the name of the product or company is not to appear on any placards pertaining to the exhibit or on booth signs shown within the area of the exhibit, nor is it to appear in the description of the exhibit published in the program. However, the committee does not object to reprints of articles pertaining to the exhibit being distributed from the scientific exhibit booth. Scientific exhibitors are free to discuss with visitors to their booths products used in their presentations.

Space assigned will be a drapery booth consisting of a backwall and two sidewalls. Each booth is 6 feet deep. The backwall will vary according to the requirements of the exhibitor, and the measurement must be noted on the application. A shelf one foot wide is provided with each booth. The height of the wall above the shelf is 5 feet, 6 inches. However, the shelf will be removed if advance request is made. By eliminating the shelf, the booth will measure 8 feet in height.

Please indicate on the application if the exhibit is free-standing. Such an exhibit will not require a drapery booth.

Please indicate on the application if a sign is incorporated with your exhibit. If so, one will *not* be ordered.

If at all possible, a photograph of the exhibit should accompany the application. If a photograph is not available, a drawing will suffice.

Application for space in the Scientific Exhibit must be submitted no later than January 1, 1974, for consideration by the committee. Applications will be acted upon by the committee as soon after that date as possible and notification sent to all exhibitors. Send *completed* application, together with photograph or drawing of exhibit, to John J. Thompson, M.D., Chairman, Committee on Scientific Exhibits, The Medical Society of New Jersey, P.O. Box 904, Trenton 08605.

1. *Time:* The exhibits will open officially at 12 noon, Saturday, May 11, and close at 5 p.m., Monday, May 13. On the intervening day the hours are 9 a.m. to 5. p.m.

2. *Installation and Dismantling:* Installation of exhibits may begin at 3 p.m., Friday, May 10, and all exhibits must be in place by 11 a.m., Saturday, May 11. Exhibits must remain intact until 5 p.m., Monday, May 13, and should be removed from the exhibit hall not later than 12 noon, Tuesday, May 14.

3. *Cost:* The Society provides free of charge such space exhibitor may require including booth with shelf, printed sign (*if requested*), and lights for illumination. The exhibitor must pay the cost of installing the exhibit, of renting tables and chairs, and for alterations and special construction, *including electrical connections.*

4. *Sponsorship:* All exhibits must be shown in the name of individual persons. The name of the institution may appear as part of the address. Medical schools, hospitals, clinics, and other institutions and organizations should not present exhibits in their own names, but rather in the names of the individuals who worked up the exhibit.

5. *Use of Space:* No exhibit shall interfere wi h another exhibit. No part of the exhibit will be allowed to extend above the top of the booth.

6. *Aisles:* Aisles must be kept clear; to this end exhibits must be so arranged that they will be inside the booth space.

7. *Advertising:* No advertising matter of any description may be distributed, nor any material shown which in any way serves for commercial propaganda.

8. *Demonstrations:* All exhibits must be in charge of competent, well-informed demonstrators. The worker who did the actual work shown, or someone who is familiar with all details, must be present at all times during exhibit hours.

9. *Motion Pictures:* Motion pictures may be shown in booths. Films are subject to preview at the discretion of the committee. They shall be non-inflammable, and *silent.* The exhibitor must supply his own screen, projector, and operator.

10. *Liability:* It is agreed that exhibitors shall indemnify and hold blameless The Medical Society of New Jersey and Haddon Hall from all liability which may ensue from any cause whatsoever relating to the use of a booth by an exhibitor. Watchmen will be supplied, but MSNJ cannot guarantee exhibitors against loss. All valuable property should be insured by the exhibitor. MSNJ and the Committee on Scientific Exhibits, while permitting an exhibit, neither endorse nor assume any responsibility for the contents of such exhibit.

11. *Awards:* Exhibits will be judged on the basis of originality, excellence of correlating facts, and excellence of presentation.

12. *Admission:* Admission to the Scientific Exhibits is by badge only. The general public is not admitted.

These regulations have become a part of the agreement between the exhibitor and The Medical Society of New Jersey. They have been formulated for the best interests of all concerned, and the cooperation of the exhibitors will be deeply appreciated.

THE MEDICAL SOCIETY OF NEW JERSEY

208th Annual Meeting

HADDON HALL ATLANTIC CITY, NEW JERSEY

APPLICATION FOR SPACE IN THE SCIENTIFIC EXHIBITS

MAY 11-13, 1974

The Committee on Scientific Exhibits will furnish uniform, painted signs for each exhibit—if requested by exhibitor. Please fill in the following form carefully. (use *typewriter,* or *print,* please)

1. TITLE (Generic names only): .....

.....

Full Name and Degree of Exhibitor(s) .....

.....

City ..... State .....

Institution (if desired) ..... City .....

Aided by commercial or pharmaceutical company .....

Exhibit constructed by: .....

2. DESCRIPTION OF EXHIBIT: Please give a brief statement telling the purpose of the exhibit, what it shows, and the conclusions reached—use generic names only. (This is for publication in the printed program.)

.....

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.....

.....

3. Is the exhibit free-standing or self-contained? .....
4. SIGN required: ..... SIGN *not* required: .....
5. Will backwall and dividers be required? (see sketch on reverse side): .....
6. SIZE OF BOOTH REQUESTED (See sketch on back) ABSOLUTE MAXIMUM: length 15', depth 6'.

   Desired inside clear backwall (8 to 15 feet) ..... Minimum inside clear blackwall .....
7. PHOTOGRAPH OR SKETCH of exhibit should accompany this application. .....
8. Has this exhibit been shown in whole or part at any other scientific meeting? .....

   If so, when? ..... and where? .....

The undersigned agrees to abide by the regulations listed.

Name .....

Address .....

Date: ....

Return application to John J. Thompson, M.D., Chairmon, Scientific Exhibits, The Medicol Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM

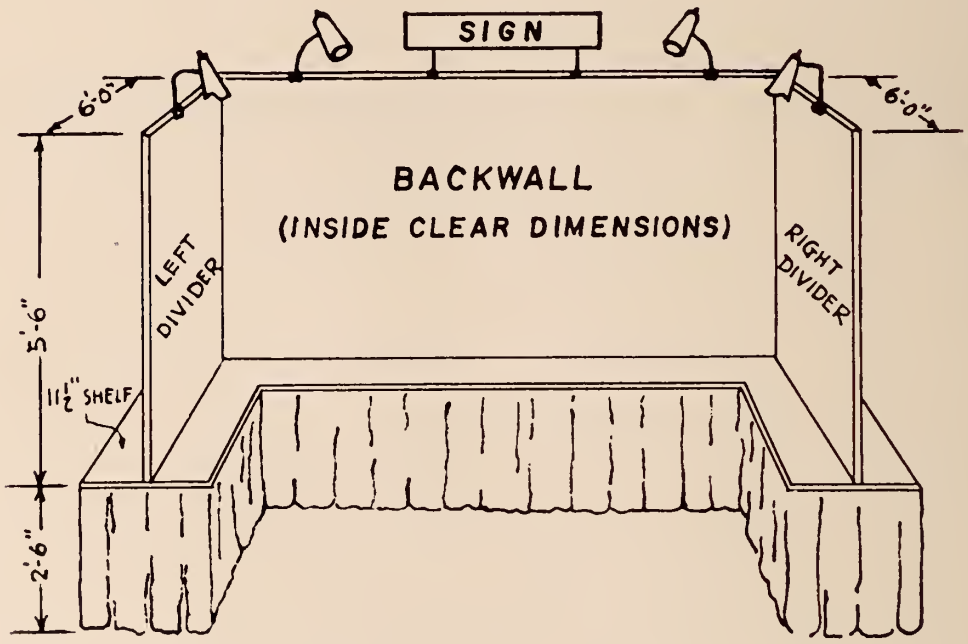
STANDARD EQUIPMENT REQUISITION FORM

Use this form only in connection with equipment to be supplied by the Committee on Scientific Exhibits. Equipment listed below will be provided at no charge to exhibitors. However, it is important that you anticipate your exact requirements in advance, as last minute changes are costly to the Society.

All scientific booths will be erected with backwall and dividers as illustrated below. Shelving and overhead lights are optional.

ILLUSTRATION OF TYPICAL BOOTH

(Booth construction: composition board covered with burlap)



Check appropriate boxes:	left divider		backwall		right divider	
Shelving	☐ yes	☐ no	☐ yes	☐ no	☐ yes	☐ no
Overhead lights	☐ yes	☐ no	☐ yes	☐ no	☐ yes	☐ no

If your exhibit will not require backwall, or left or right dividers, please advise.

If a sign is incorporated with your exhibit, please advise, and one will *not* be ordered for you.

COMPLETE ALL ITEMS ON BOTH SIDES OF FORM

LETTERS TO THE JOURNAL

Another View on Inversion Injuries on the Ankle

October 16, 1973

Dear Editor:

Dr. Chirls' article on Inversion Injuries of the Ankle (Vol. 70, No. 10, October, 1973, p. 751) draws a rather pedantic conclusion on the management of ankle injuries that would certainly be challenged by experts in the field.

The value of arthrography in acute ankle injuries remains in doubt. Most workers feel it is of no value in clinical management. Certainly it would not be needed to confirm a clinical impression of instability and it is definitely not needed to confirm a positive stress inversion view. Comparison arthrograms of the normal ankle are never needed and constitute a meddlesome procedure on the uninjured ankle. Comparison stress views yes but arthrograms never.

Properly performed stress views, which can be done without anesthesia in most cases, are extremely helpful and negative findings are as valuable as positive ones, the work of Brostrom notwithstanding. Less than five degrees of talar tilt is probably normal. More than twelve degrees is highly suggestive of rupture of at least anterior talofibular and more than twenty-five degrees is virtually diagnostic of both anterior talofibular and calcaneo-fibular ligaments.

Dr. Chirls does not break down his cases by age, sex, athletic intent, or occupation nor does he define the various degrees of injury and the correlation of results with severity of injury. For instance, were all the "poor" cases those with more than twenty-five degrees of talar tilt to begin with? The analysis of results is worthless without this correlation.

Very few late cases will yield leaks on arthrography. They all seal over with scar and fibrous tissue which makes an effective seal but not an effective ligament. The false negative arthrograms in late cases are the rule rather than the exception.

In all cases, operated on recently at the Rutgers Medical School, for gross instability following fresh injury in college athletes, the ruptured ends of the ligaments were found rolled up like window shades with a large gap between them. Without surgical approximation they could heal only with fibrous scar to bridge the gap. We feel that this would not give a serviceable ankle for an active athlete. A controlled study is underway and the answer definitely is not in as yet. Surely Dr. Chirls' contention that his follow-up arthrograms negate surgical repair is wholly unwarranted based upon his or anyone else's data thus far.

(signed) Richard M. Ball, M.D.

No Barrier to Librium® or Valium®

October 30, 1973

Dear Sir:

It has been brought to our attention that the letter from Albert G. Hulett, M.D., entitled, "A New FDA Regulation?," which appeared in the October 1973 isue of *The Journal,* contained an inaccurate statement.

Doctor Hulett stated: "From items in the daily papers it seems that the FDA is about to remove from the market two very valuable drugs, Librium® and Valium®."

We would like to assure your readers that the FDA is in no way considering removing these psychotherapeutic agents from the market.

At a press conference held on Wednesday, August 15, both products were proposed for inclusion at a future date under Schedule IV of the Controlled Substances Act. Following

this press conference, some confusion and inaccuracies were generated by the news media and these apparently resulted in an erroneous interpretation by Doctor Hulett. The proposed new regulation does not in any way question the therapeutic usefulness of these products nor the physician's prerogative to prescribe Librium® and Valium® when indicated.

(signed) Bruce H. Medd, M.D.
(Director, Professional Services,
Roche Laboratories)

ANNOUNCEMENTS

Graduate Courses in Medicine

The following schedule, in the series, "Advances in Medicine," has been announced by the Bergen Pines County Hospital, Paramus. Sessions are held in the hospital auditorium from 9:30 to 11 a.m. on the Wednesdays indicated and collation is offered at 9 o'clock. For further information write to the Office of Medical Education, Bergen Pines County Hospital, Paramus 07652.

December 5	Urticaria and Angioedema David J. McConnell, M.D. College of Physicians and Surgeons, New York
December 12	Cushing's Syndrome Norman H. Ertel, M.D. VA Hospital, East Orange
December 19	Clinical Pathology Conference Edward Wagman, M.D. Bergen Pines County Hospital, Paramus

Psychiatric Graduate Programs

Fair Oaks Hospital in Summit, in cooperation with the Academy of Medicine of New Jersey, has arranged the following programs in the series, "Current Topics in Psychiatry:"

December 5	Hepatitis Willem Ten Hove, M.D.
December 19	Thyroid Diseases Theodore Dull, M.D.
January 9	Biomedical Ethics Kenneth Vaux, D.Th.
January 23	Diabetics with Mental Illness Robert Areson, M.D.
February 6	Headaches John R. Graham, M.D.
February 20	Electro-Convulsive Therapy Richard Abrams, M.D.

Sessions are held from 3 to 4:30 p.m. (Wednesdays) at the hospital, 19 Prospect Street, Summit. Further information may be obtained from Granville L. Jones, M.D., Director of Research and Education.

Graduate Lectures in Surgery

The following programs have been announced for the 1973-1974 "Distinguished Lecture Series" offered by the Department of Surgery of the New Jersey Medical School, CMDNJ:

December 10	Hiatus Hernia G. Robert Mason, M.D., Chairman Department of Surgery University of Maryland School of Medicine
January 28	Benign Lesions of the Breast William T. Fitts, Jr., M.D., Chairman Department of Surgery University of Pennsylvania School of Medicine
February 11	Metastatic Tumors of the Lung Paul C. Adkins, M.D., Chairman Department of Surgery George Washington University School of Medicine
March 22	Dissecting Aneurysm Charles A. Hufnagel, M.D. Department of Surgery Georgetown University School of Medicine

Lectures are held at 4 p.m. in the amphitheater, 2nd floor, Martland Hospital, Newark. There is no charge. Guarded parking is available in parking lot M, 12th and Bergen Streets. For further information, please write to Eric J. Lazaro, M.D., Professor of Surgery, Martland Hospital Unit, CMDNJ, 65 Bergen Street, Newark 07107.

Pulmonary Disease Conferences

Rutgers Medical School, in conjunction with the New Jersey Thoracic Society, the New Jersey Lung Association, and the Delaware-Raritan Tuberculosis and Respiratory Disease Association, announces the following pulmonary disease conferences during 1973-1974. Lectures are held at 1:00 p.m. on the Wednesdays indicated at the Link Conference Center, Rutgers Medical School in Piscataway. Discussion of clinical material will follow each presentation.

January 23	Pathogenesis of Emphysema Philip Kimbel, M.D. Einstein Medical Center (Philadelphia)
February 27	Management of Lung Cancer J. W. Mackenzie, M.D. Dean, Rutgers Medical School

Programs for March through June will be announced in a later issue. For additional information, please write to Norman H. Edelman, M.D., Chief, Pulmonary Diseases Division, Department of Medicine, Rutgers Medical School, CMDNJ, University Heights, Piscataway, New Jersey 08854.

ACS to Meet in Rome

The New Jersey Chapter of the American College of Surgeons has scheduled its annual pilgrimage this year to Rome—March 9 to 19, 1974. The "package" includes round-trip, first-class air transportation to Rome, medical symposia each morning, and sightseeing and social activities for afternoons and evenings. Optional excursions for the week-end prior to returning home are available to Florence or to Sorrento/Capri. Total cost of the basic trip is $598 per person; $95 additional for the optional tour. Registration fee is $20 and a deposit of $100 per person is necessary to reserve accommodations. Please make checks payable to the New Jersey Chapter of the ACS and mail to Charles L. Zukaukas, M.D., 255 Third Avenue, Long Branch, New Jersey 07740.

Industrial Health Conference

The Industrial Medical Association and the American Association of Industrial Nurses have scheduled the 1974 industrial health conference for April 28 to May 2 in Bal Harbour, Florida. Sessions are designed for industrial physicians, industrial nurses, safety engineers, hygienists, public health officials, academicians, and management representatives. The scientific program will be augmented by scientific and technical exhibits, and there will be workshops in occupational medical practice. Registration is open to anyone interested in the health of the working population. For further information, please write to Doris Flournoy, American Industrial Health Conference, 150 North Wacker Drive, Chicago.

American College of Surgeons' Spring Meeting

A four-day educational program is being arranged by the American College of Surgeons for May 25 to 28 in Houston, Texas. Eight nine-hour courses will be offered, supplemented by two days of symposia, panels, lectures, and motion pictures. Surgeons may select from the following courses:

Fluids and Electrolytes
Cardiovascular Surgery
Cancer
Plastic Surgery
Shock
Gastrointestinal Surgery
Surgery of the Hand
Urologic Surgery

The fee for each course, including manual, is $40. Registration at the meeting is a prerequisite for course registration and is without charge to Fellows and surgical residents; fee for non-Fellows is $50. Registered nurses and interns may register without charge for the general sessions but are not eligible for the graduate courses. Additional course information and forms for registration and housing are available from Edwin Gerrish, M.D., Assistant Director, American College of Surgeons, 55 East Erie Street, Chicago 60611.

ANNUAL MEETING MAY 11-14, 1974

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1973
December

Middlesex General Hospital, American Academy of Family Practice, and Academy of Medicine of New Jersey
Middlesex General Hospital, New Brunswick

12 *Acute Drug Intoxications*

19 *Determinants of Emotional Health*

19 Helene Fuld Hospital and Academy of Medicine of New Jersey
Helene Fuld Hospital, Trenton
Endoscopy of Gastrointestinal Tract

8 Academy of Medicine of New Jersey
Morristown Memorial Hospital, Morristown
Surgery of the Hand

10 CMDNJ—New Jersey Medical College
Martland Hospital, Newark
Hiatus Hernia

11 Academy of Medicine of New Jersey
Paul Kimball Hospital, Lakewood
Thyroid Diseases

12 Riverside, Dover General and St. Clare's Hospitals
Riverside Hospital, Boonton
Hepatitis B-Antigen and Chronic Liver Disease

12 Academy of Medicine of New Jersey and New Jersey Radiology Society
Morristown Memorial Hospital
Angiography

12 Academy of Medicine of New Jersey
Mountainside Hospital, Montclair
Surgery of Traumatized Hand

12 Academy of Medicine of New Jersey
Runnells Hospital, Berkeley Heights
Clinical Electrocardiography

18 Academy of Medicine of New Jersey
Holy Name Hospital, Teaneck
Proper Use of Blood Gases

19 Academy of Medicine of New Jersey
Trenton Psychiatric Hospital, Trenton
Fluid and Electrolyte Imbalance

19 Academy of Medicine of New Jersey
Fair Oaks Hospital, Summit
Thyroid Diseases

19 Veterans Administration and CMDNJ
Veterans Hospital, East Orange
Role of Respiratory Muscles in Respiratory Failure

1974
January

Middlesex General Hospital, American Academy of Family Practice, and Academy of Medicine of New Jersey
Middlesex General Hospital, New Brunswick

2 *Dermatology and the Clinician*

9 *Hemoptysis*

16 *Office Evaluation and Management of the New Hypertensive Patient*

23 *Medical Complications of Acute Myocardial Infarction*

30 *Surgical Considerations in Management of Myocardial Infarction*

8 New Jersey Dermatological Society and Academy of Medicine of New Jersey
Overlook Hospital, Summit
Genetic Disease and Inheritance Patterns

Helene Fuld Hospital and Academy of Medicine of New Jersey
Helene Fuld Hospital, Trenton

9 *Hepatitis*

16 *Acute Abdomen*

23 *Inflammation of Large Bowel*

10 Academy of Medicine of New Jersey
Helene Fuld Hospital, Trenton
Diagnosis In Treatment of Shock

16 Academy of Medicine of New Jersey
Trenton Psychiatric Hospital, Trenton
Alcoholism

16 Academy of Medicine of New Jersey
VA Hospital, East Orange
Respiratory Phenomena and Metabolic Acidosis

17 Academy of Medicine of New Jersey
Englewood Hospital, Englewood
Newer Concepts of Hepatitis

18 Academy of Medicine of New Jersey
Perth Amboy General Hospital
Breast Cancer

21 Academy of Medicine of New Jersey
Ancora Psychiatric Hospital, Hammonton
Medical-Surgical Emergencies in Psychiatric Practice

22 Academy of Medicine of New Jersey
Warren Hospital, Phillipsburg
Acupuncture

23 **New Jersey Thoracic Society**
Rutgers Medical School, Piscataway
Pathogenesis of Emphysema

23 **Academy of Medicine of New Jersey**
Fair Oaks Hospital, Summit
Difficult Diabetics With Mental Illness

23 **Academy of Medicine of New Jersey and St. Joseph's Hospital**
St. Joseph's Hospital, Paterson
Clinical Symposia—Series II: Diabetes

24 **Radiological Society of New Jersey and Academy of Medicine of New Jersey**
Hospital Center at Orange
Venography of the Upper and Lower Extremities

28 **CMDNJ, New Jersey Medical College and Academy of Medicine of New Jersey**
Martland Hospital, Newark
Benign Lesions of the Breast

30 **Academy of Medicine of New Jersey**
College of Medicine and Dentistry, Newark
Use of Blood Products for Transfusion

February

5 **New Jersey Dermatological Society and Academy of Medicine of New Jersey**
St. Michael's Medical Center, Newark
Antibiotic Therapy

5 **Academy of Medicine of New Jersey**
Fairleigh Dickinson University,
School of Dentistry, Hackensack
Oral Medicine

Middlesex General Hospital, American Academy of Family Practice, and Academy of Medicine of New Jersey
Middlesex General Hospital, New Brunswick

6 *Hormones, Hypertension, and Vascular Disease*

13 *Perspectives in Diabetes*

20 *Trends in Hyperalimentation*

27 *Biological Role of the Lymphocyte*

Helene Fuld Hospital and Academy of Medicine of New Jersey
Helene Fuld Hospital, Trenton

6 *Pancreatic Diseases*

27 *Respiratory Insufficiency*

11 **CMDNJ, New Jersey Medical College and Academy of Medicine of New Jersey**
Martland Hospital, Newark
Mestastatic Tumors of the Lung

12 **New Jersey Dermatological Society**
Mountainside Hospital, Montclair
Use and/or Abuse of Antibiotic Therapy

12 **Academy of Medicine of New Jersey**
Paul Kimball Hospital, Lakewood
Diagnosis and Treatment of Hypertension

13 **Academy of Medicine of New Jersey**
United Presbyterian Hospital, Newark
Ulcerative Colitis

18 **Academy of Medicine of New Jersey**
Ancora Psychiatric Hospital, Hammonton
Medical-Legal Aspects of Medicine and Surgery

20 **Academy of Medicine of New Jersey**
VA Hospital, East Orange
Resistance to Pulmonary Infection

20 **Academy of Medicine of New Jersey and St. Joseph's Hospital**
St. Joseph's Hospital, Paterson
Clinical Symposia—Series VI: Neurology

20 **Academy of Medicine of New Jersey**
Helene Fuld Hospital, Trenton
Acupuncture

21 **Academy of Medicine of New Jersey**
Englewood Hospital, Englewood
Laboratory Interpretations

26 **Academy of Medicine of New Jersey**
Warren Hospital, Phillipsburg
Diagnosis in the Anemic Patient

27 **New Jersey Thoracic Society**
Rutgers Medical School, Piscataway
Lung Cancer

28 **Radiological Society of New Jersey and Academy of Medicine of New Jersey**
Hospital Center at Orange
Tumors of the Small Bowel

March

Middlesex General Hospital, American Academy of Family Practice, and Academy of Medicine of New Jersey
Middlesex General Hospital, New Brunswick

6 *Paraneoplastic Syndromes*

13 *Neurological Complications of Systemic Cancer*

20 *Metabolic Bone Disease*

27 *Untoward Effects of Long-Term Steroid Therapy*

12 **New Jersey Dermatological Society and Academy of Medicine of New Jersey**
Barnert Hospital, Paterson
Host Defenses in Malignant Melanoma

12 **Academy of Medicine of New Jersey**
Paul Kimball Hospital, Lakewood
Medical-Legal Aspects of Medicine and Surgery

13 **Academy of Medicine of New Jersey**
Hunterdon Medical Center, Flemington
Infectious Diseases

16 **New Jersey Chapter, American Academy of Family Physicians**
Cherry Hill Inn, Cherry Hill
Annual Meeting

20 **Academy of Medicine of New Jersey**
Trenton Psychiatric Hospital, Trenton
Drug Addiction

21 **Academy of Medicine of New Jersey**
Englewood Hospital, Englewood
Proper Use of Antibiotics

24 CMDNJ–New Jersey Medical School and Academy of Medicine of New Jersey
Location to be announced
Problems in Obstetrics and Gynecology

26 Academy of Medicine of New Jersey
Warren Hospital, Phillipsburg
Diagnosis in Neurology and Neuro-Surgery

28 Radiological Society of New Jersey and Academy of Medicine of New Jersey
Hospital Center at Orange
Lumbar Spondylosis

April

Middlesex General Hospital, American Academy of Family Practice, and Academy of Medicine of New Jersey
Middlesex General Hospital, New Brunswick

3 *Eye Care in Family Practice*

10 *Gynecological Problems in Office Practice*

17 *Emergencies of Pregnancy and Labor*

24 *Pulmonary Function Testing*

4 Academy of Medicine of New Jersey
Helene Fuld Hospital, Trenton
New Developments in Scanning

10 Academy of Medicine of New Jersey
Runnells Hospital, Berkeley Heights
Acupuncture

15 Academy of Medicine of New Jersey
Ancora Psychiatric Hospital, Hammonton
Alcoholism

17 Academy of Medicine of New Jersey and St. Joseph's Hospital
St. Joseph's Hospital, Paterson
Clinical Symposia–Series VIII: Hypertension

18 Academy of Medicine of New Jersey
Englewood Hospital, Englewood
Bleeding Diseases

23 Academy of Medicine of New Jersey
Warren Hospital, Phillipsburg
Differential Diagnosis of Arthritis

25 Radiological Society of New Jersey and Academy of Medicine of New Jersey
Hospital Center at Orange
Total Body Scanning

May

Middlesex General Hospital, American Academy of Family Practice, and Academy of Medicine of New Jersey
Middlesex General Hospital, New Brunswick

1 *Environmental Cancer in the Year 2000*

8 *Unusual Causes of Heart Failure*

15 *Hemorrhagic and Septic Shock*

22 *Developments in Infectious Diseases*

29 *ENT in Office Practice*

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The family of our late Editor, Henry A. Davidson, M.D., has requested that, in lieu of other tributes, donations be made in his memory either to the Academy of Medicine of New Jersey or to the Essex County Mental Health Association. It is planned to initiate an annual symposium in Dr. Davidson's honor and donations should be made to the Educational Fund of the Academy of Medicine of New Jersey, 2424 Morris Avenue, Union, New Jersey 07083.

OBITUARIES

Dr. Jacob August

On October 1, 1973, one of Essex County's well-known surgeons, Jacob August, M.D., died, at the untimely age of 55. He was a graduate of New York Medical College, class of 1943. Following completion of service with the Army Medical Corps, Dr. August served a residency in general surgery and became board certified in that field. He was also a Fellow of the American College of Surgeons and a member of the Academy of Medicine of New Jersey. He was attending surgeon at East Orange General Hospital, Presbyterian Hospital in Newark, and Orange Memorial Hospital. Dr. August had been active in the affairs of the Essex County Medical Society.

Dr. Martin Chomko

One of East Brunswick's prominent obstetricians and gynecologists, Martin Chomko, M.D., died on October 4, 1973, at the early age of 53. Dr. Chomko had come to Middlesex County eleven years ago from Scranton, Pennsylvania. He was a 1944 graduate of the Jefferson Medical College and had completed his graduate work at the Metropolitan Hospital in New York. He was a Fellow of the American College of Obstetricians and Gynecologists. Dr. Chomko was active in civic affairs in his community and was a member of the East Brunswick Board of Health. He had served as flight surgeon with the U.S. Air Force and was on the staff at St. Peter's Hospital in New Brunswick.

Dr. Michael Conti

The sudden death on October 7, 1973, brought to an end the career of one of Jersey City's beloved general practitioners, Michael Conti, M.D. Born in Italy in 1895, Dr. Conti received his M.D. degree from the Medical School of the University of Rome in 1921 and shortly thereafter emigrated to Jersey City, where he practiced medicine for over fifty years. His colleagues described him as "a great humanitarian and humble philanthropist," who was more concerned with his patient's welfare than in collecting his fees. Dr. Conti was active in civic affairs and in 1953 was given the Outstanding American of the Year Award by the Jersey City Independence Day Committee.

Dr. Edwin D. Harrington

At the untimely age of 50, Edwin D. Harrington, Jr., M.D., of Moorestown, died on September 20, 1973. Dr. Harrington won his M.D. degree from the University of Pennsylvania School of Medicine, class of 1949. He also held a master's in public health from Yale University. After completion of residency training at Children's Hospital in Philadelphia, he began the practice of pediatrics in Moorestown in 1954. Dr. Harrington was board certified in his specialty and was a Fellow of the American Academy of Pediatrics and a member of the Philadelphia College of Physicians. He was associate professor of pediatrics at Jefferson Medical College and headed the children and youth project at the medical center there. He was also on the staff at Burlington County Hospital in Mount Holly and at Zurbrugg Memorial Hospital in Riverside.

Dr. Dominick A. Introcaso

Word has just been received of the death on August 26, 1973, of Dominick A. Introcaso, M.D., of Jersey City, at the age of 72. Dr. Introcaso was a graduate of the Long Island College of Medicine, class of 1924 and returned to his native city to establish a practice in general surgery, with special interest in obstetrics and gynecology. He was a Fellow of the American College of Obstetrics and Gynecology, and of the International College of Surgeons. Before retirment he was on the surgical staff at the Medical Center in Jersey City. Dr. Introcaso was a member of the Academy of Medicine of New Jersey and the American Geriatrics Society.

Dr. John J. Knightly

John Joseph Knightly, M.D., died suddenly on October 18, 1973, while attending a meeting of the American College of Surgeons in Chicago, where he had presented a film on a surgical procedure developed by him. Dr. Knightly was a 1954 graduate of Cornell Medical School and took his residency in general surgery at Georgetown University Medical Society and in tumor surgery at the Memorial Sloan-Kettering Cancer Center. He was a diplomate in surgery, a Fellow of the American College of Surgery, and a member of the Academy of Medicine of New Jersey. He was director of surgery at Martland Hospital in Newark, and was on the attending staffs at Christ Hospital, Greenville Hospital, and the Medical Center in Jersey City. He was a member of the executive committee of the New Jersey Chapter of the American Cancer Society. Dr. Knightly was only 47 years old at the time of his death.

Dr. Louis J. O'Lini

Word has been received of the sudden death on September 26, 1973, of Louis J. O'Lini, M.D., of Toms River. Born in 1910, Dr. O'Lini received his medical degree from Hahnemann Medical College in 1935 and had been a general practitioner, with special interest in gynecology, in Newark until moving to Toms River in 1964, where he continued to practice. He was a member of the staff at St. Michael's Hospital in Newark and at the Community Hospital in Toms River.

Dr. Frank M. Pugliese, Jr.

Death, on October 3, 1973, as the result of an automobile accident, cut short the promising career of Frank M. Pugliese, Jr., M.D. Born in 1936, Dr. Pugliese won his M.D. degree from Hahnemann Medical College in 1962 and took his internship and residency at Baylor University Medical Center in Dallas and at Hahnemann Hospital in Philadelphia. After two years' service in the Army Medical Corps he came to Summit and opened an office for the practice of surgery. He had special interest in vascular and thoracic surgery and held a staff appointment in that department at Overlook Hospital in Summit. Dr. Pugliese was a member of the American College of Surgeons and of our Union County Medical Society.

Dr. Edward J. Whelan

One of Essex County's senior members, Edward J. Whelan, M.D., of Nutley, died on August 8, 1973, at the grand age of 87. Dr. Whelan was graduated from the University of Virginia Medical College in 1908 and practiced general surgery in the Nutley area for many years. He was honored, in 1960, on the golden anniversary of his membership on the staff at St. Mary's Hospital in Passaic. Dr. Whelan was a Fellow of the American College of Surgeons.

Dr. Arnold A. Zacchino

Bergen County lost one of its well-known physicians and Fort Lee one of its most beloved citizens, with the death on October 16, 1973, of Arnold A. Zacchino, M.D. Born in 1907, Dr. Zacchino received his M.D. degree from Georgetown University School of Medicine in 1933. Known as an "old school" general practitioner, he had served his home community for 35 years, and had been physician to the Board of Health there for nearly as long. He was interested in public health medicine and was medical director of the borough of Fort Lee, where he was instrumental in opening a modern health station to replace the old baby station that had been in existence since the early 1940's. He was also chairman of the medical committee of Fort Lee's narcotics council, and medical director of the public school system and physician for high school sports teams. Dr. Zacchino had been honored in 1958 as the outstanding Italian-American citizen of Fort Lee, and, in 1962, by the Fort Lee Board of Health for his contributions to public health in the community. He was a member of the attending staff at the Englewood Hospital.

BOOK REVIEWS

Synoptic Functional Neuroanatomy. Wendell Krieg, Ph.D. Evanston, Illinois, Brain Books. 1973. Pp. 75. Illustrated. ($6)

Dr. Krieg has produced a small book and diachrome booklet intended to fit the needs of students of paramedical psychology, biology, dentistry, medicine, and the specialties of psychiatry and neurology. He is a master of three-dimensional drawing. The book has great artistic appeal. An abundance of information is portrayed in projection drawings. It is difficult to estimate how much a neophyte might grasp but the gross brain can certainly be envisioned forever after looking at the diachrome drawings in all the colors of the spectrum from the bright yellow of the areas of higher mentation to the red primary motor, blue primary sensory, green associational and the sky blue of the visual areas. Inner details are portrayed in myriad array for the student who, with magnifying glass in hand, will take the pains to pursue the text and the numbered diagrams. In some ways the presentation brings to mind the Lord's Prayer written on the head of a pin, a great accomplishment but a doubtful way to spread the faith. Nevertheless, the pursuit of the text and the diagrams is calculated to alter the initial resemblance to a bouquet of colored spaghetti and, like the poet's pen, the numbered three-dimensional diagrams bring to airy nothings a local habitation and a name—from stria medullaris to habenula, from hippocampus to fornix, from motor cortex to the decussation of the pyramids, an artistic study of anatomy, a collector's item at a good price.

Ira S. Ross, M.D.

The Low Blood Sugar Cookbook. Margo Blevin and Geri Ginder. New York, Doubleday, 1973. Pp. 520. ($8.95).

To accept the need for a low-blood-sugar cookbook one must be ready to accept the concept of a chronic hypoglycemia state. If many Americans suffer from hypoglycemia and can be helped by a high protein, low carbohydrate diet then this book contains many fine recipes that would relieve the monotony of such a diet.

The authors deserve great credit for the completeness of their menus. Much research has been done in obtaining sources of food, substitutes for high carbohydrate dishes, and interesting ways to prepare foods. In reading the text however you get the feeling that this type of diet must become a way of life to those who follow it. I don't know if such a regimen is that important. The choice is yours.

Gerald F. Hansen, M.D.

Dr. Thompson's New Way for You to Cure Your Aching Back. Jess Stearn. New York, Doubleday, 1973. Pp. 203. Illustrated. ($7.95)

This tract concerns itself with the displacement of the sacroiliac joint, and the author's method of reducing it by a form of flexion-abduction exercises. Neither the concept nor the recommended "cure" can be described as new.

Much of the text is devoted to descriptions of the author's rapid analysis and unfailing correction of back pain, scoliosis, migraine headache, sinus trouble, and other ailments. No failures are described. A few quotes from the text: "I have never had a failure . . . it always works." "The first thing I do with a child with a bellyache is to check the sacroiliac." "You nearly always will have a displaced sacroiliac with a migraine." "Ninety per cent of all stresses in the spine from the lower back to the neck are related to a pelvic tilt from a displaced hipbone or sacroiliac."

This book should not be recommended to the general public to whom it is directed. It is a rehash of ancient beliefs supported by faulty anatomy and physiology. The physician should not waste his time with it.

Daniel J. O'Regan, M.D.

Current Issues in Mental Health. M. F. Shore, Ph.D. and S. E. Golann, Ph.D., Editors. Washington, D.C., U.S. Government Printing Office; DHEW Publication No. 73-9029. Pp. 55. (Softback—price not indicated.)

In 1970, the American Orthopsychiatric Association held a seminar on ethical problems in the mental health field. The eight papers presented there are brought together in this compact and thought-provoking little volume. It presents, in varying depth, such problems as the storage and protection of confidential personal data, the ethics of manipulating people by "brain-washing" or similar social psychological technics, the responsibility (if any) of social science practitioners to try to change unacceptable laws, attitudes toward knowledge of a client's or patient's illegal behavior, responsibilities for following up disturbed activities after group therapy sessions are concluded, ethical problems associated with the availability of computerized data, the reality of the "impartiality" of scientists including social scientists, the concept of the psychologist or social worker as an advocate of the client or patient, and sensitive ethical dilemmas related to technics in pursuit of sociologic or psychological data. Of the eight contributors, not one is an M.D., perhaps a sad commentary on our profession's inability to see ourselves as social scientists.

Abraham Leff, M.D.

Seeing and the Eye. G. Hugh Begbie, Ph.D. New York, Doubleday, 1973. Pp. 227. Illustrated. (Softback—$2.95).

This little book accomplishes what its author sets out in the preface. He states that the reader is "not assumed to have any special prior knowledge." He makes no claim that it is a comprehensive book and therefore there are appended very good references for more detailed reading.

The chapters deal with the seeing, the perception, and the interpretation of external objects. The physiology of vision, transmission of nerve impulses, and the mechanisms of color vision are explained. The author traces the visual impulses to the brain with its interconnections described. The reader gets a good exposition of the psychology and indeed the philosophy of vision.

All in all, this introduction to vision contains some interesting facts, logically arranged and explained.

S. Jerome Greenfield, M.D.

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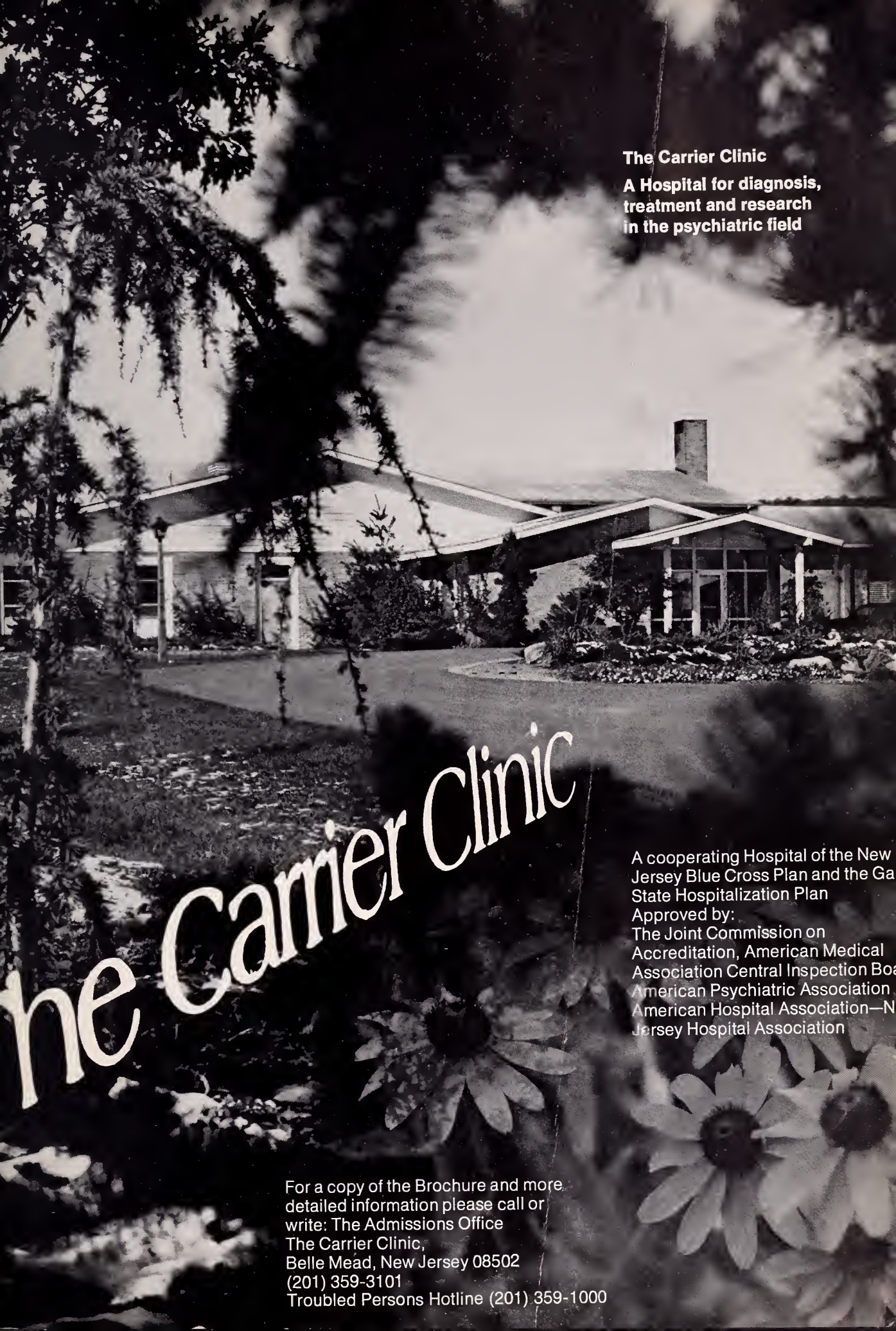
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The achievement of desired therapeutic results is often a function of the dosage *strength* as well as the drug's intrinsic action. Thus, when anxiety is *severe*, the 25-mg strength of Librium frequently provides the necessary antianxiety action with a minimum of unwanted adverse reactions. Librium 25 mg is a convenient dosage form for the relief of severe, incapacitating anxiety, specifically formulated to supplement your counsel and reassurance.

Benefits-to-risks ratio permits higher dosage



For over 13 years, Librium has been recognized for its excellent benefits-to-risks ratio, an asset in the *higher* dosage ranges as in more common clinical applications. Thus, the frequency of dosage with Librium 25 mg can be flexibly adjusted to the needs and response of the individual patient, up to 100 mg daily if required. Total daily dosage for the elderly and debilitated should not exceed 20 mg. When severe anxiety has been reduced, Librium dosage should be correspondingly reduced or discontinued entirely.

basic support in severe anxiety

Librium® 25 mg (chlordiazepoxide HCl) 1 capsule t.i.d./q.i.d.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, N J 07110

New York Academy of Medicine
2 East 103rd Street
New York, New York 10029

Before prescribing, please co plete product information, a sumr which follows:

Indications: Relief of anxiety occurring alone or accompanying va states.

Contraindications: Patients w hypersensitivity to the drug.

Warnings: Caution patients al combined effects with alcohol and ot depressants. As with all CNS-acting patients against hazardous occupatic complete mental alertness (*e.g.*, oper ery, driving). Though physical and p dependence have rarely been reporte mended doses, use caution in admin addiction-prone individuals or thos increase dosage; withdrawal sympto convulsions), following discontinua drug and similar to those seen with have been reported. Use of any drug lactation, or in women of childbearing that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitor and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

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DUE IN ~~TWO~~ 4 WEEKS UNLESS RENEWED
NOT RENEWABLE AFTER 8 WEEKS

DATE BORROWED	BORROWER